109TH CONGRESS
1ST SESSION

S. 1503

To reduce healthcare costs, expand access to affordable healthcare coverage, and improve healthcare and strengthen the healthcare safety net, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 26, 2005

Mr. FRIST (for himself, Mr. MCCONNELL, Mr. GREGG, Mr. ENZI, Ms. MURKOWSKI, and Mr. DEMINT) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To reduce healthcare costs, expand access to affordable healthcare coverage, and improve healthcare and strengthen the healthcare safety net, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Healthy America Act of 2005''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Health care costs are growing rapidly, putting health insurance and needed care out of reach for too many Americans.

(2) Rapidly growing health care costs pose a threat to the United States economy, as they make American businesses less competitive and make it more difficult to create new jobs.

(3) Growing health care costs are compromising the stability of health care safety net and entitlement programs.

(4) There are a series of steps Congress can and should take to slow the growth of health care costs, expand access to health coverage, and improve access to quality health care for millions of Americans.

TITLE I—MAKING HEALTH CARE MORE AFFORDABLE

Subtitle A—Medical Liability Reform

SEC. 101. SHORT TITLE.

This subtitle may be cited as the ''Patients First Act of 2005''.

SEC. 102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the current health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities

that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions

have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals;

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 103. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years

after the date of manifestation of injury unless tolled for any of the following:

(1) Upon proof of fraud.

(2) Intentional concealment.

(3) The presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 104. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, the full amount of a claimant's economic loss may be fully recovered without limitation.

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages recovered may be as much as $250,000, regardless of the

number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit, an award for future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this sec-

tion, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 105. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, di-

agnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 106. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 107. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such

person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any pro-

ceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(c) NO PENALTIES FOR PROVIDERS IN COMPLIANCE WITH FDA STANDARDS.—A health care provider who prescribes a medical product approved or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product.

SEC. 108. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judg-

ments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

SEC. 109. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product

or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and

loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defend-

ants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans, and the terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act

(21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care

incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 110. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this

subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or

permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS.—Any issue that is not governed by any provision of law established by or under this subtitle (including State standards of negligence) shall be governed by otherwise applicable State or Federal law. This subtitle does not preempt or supersede any law that imposes greater protections (such as a shorter statute of limitations) for health care providers and health care organizations from liability, loss, or damages than those provided by this subtitle.

(c) STATE FLEXIBILITY.—No provision of this subtitle shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this subtitle) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 104(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Health Information Technology

CHAPTER 1—GENERAL PROVISIONS

SEC. 121. IMPROVING HEALTH CARE, QUALITY, SAFETY, AND EFFICIENCY.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXIX—HEALTH INFORMATION TECHNOLOGY

"SEC. 2901. DEFINITIONS.

''In this title:

''(1) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a phy-

sician (as defined in section 1861(r) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

''(2) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

''(3) HEALTH INSURANCE PLAN.—The term 'health insurance plan' means—

''(A) a health insurance issuer (as defined in section 2791(b)(2));

''(B) a group health plan (as defined in section 2791(a)(1)); and

''(C) a health maintenance organization (as defined in section 2791(b)(3)).

''(4) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

''(5) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.

''(6) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF HEALTH INFORMATION TECHNOLOGY.

''(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of the National Coordinator of Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the Secretary, in consultation with the President, and shall report directly to the Secretary.

''(b) Purpose.—It shall be the purpose of the Office to coordinate with relevant Federal agencies and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure that—

''(1) ensures that patients' individually identifiable health information is secure and protected;

''(2) improves health care quality, reduces medical errors, and advances the delivery of patient-centered medical care;

''(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;

''(4) ensures that appropriate information to help guide medical decisions is available at the time and place of care;

''(5) promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes; and

''(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—The National Coordinator shall—

''(1) provide support to the public-private American Health Information Collaborative established under section 2903;

''(2) serve as the principal advisor to the Secretary concerning the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

''(3) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information;

''(4) ensure the adoption and implementation of standards for the electronic exchange of health infor-

mation to reduce cost and improve health care quality;

''(5) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

''(6) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;

''(7) advise the President regarding specific Federal health information technology programs; and

''(8) submit the reports described under section 2903(i) (excluding paragraph (4) of such section).

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Fed-

eral efforts with respect to the establishment of the Office, regardless of whether such efforts were carried out prior to or after the enactment of this title.

"SEC. 2903. AMERICAN HEALTH INFORMATION COLLABORATIVE.

''(a) PURPOSE.—The Secretary shall establish the public-private American Health Information Collaborative (referred to in this section as the 'Collaborative') to—

''(1) advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

''(2) serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology; and

''(3) recommend standards (including content, communication, and security standards) for the electronic exchange of health information for adoption by the Federal Government and voluntary adoption by private entities.

''(b) COMPOSITION.—

''(1) IN GENERAL.—The Collaborative shall be composed of—

''(A) the Secretary, who shall serve as the chairperson of the Collaborative;

''(B) the Secretary of Defense, or his or her designee;

''(C) the Secretary of Veterans Affairs, or his or her designee;

''(D) the Secretary of Commerce, or his or her designee;

''(E) representatives of other relevant Federal agencies, as determined appropriate by the Secretary; and

''(F) representatives from among the following categories to be appointed by the Secretary from nominations submitted by the public—

''(i) consumer and patient organizations;

''(ii) experts in health information privacy and security;

''(iii) health care providers;

''(iv) health insurance plans or other third party payors;

''(v) standards development organizations;

''(vi) information technology vendors;

''(vii) purchasers or employers; and

''(viii) State or local government agencies or Indian tribe or tribal organizations.

"(2) CONSIDERATIONS.—In appointing members under paragraph (1)(F), the Secretary shall select individuals with expertise in—

"(A) health information privacy;

"(B) health information security;

"(C) health care quality and patient safety, including those individuals with experience in utilizing health information technology to improve health care quality and patient safety;

"(D) data exchange; and

"(E) developing health information technology standards and new health information technology.

"(3) TERMS.—Members appointed under paragraph (1)(G) shall serve for 2 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

"(c) RECOMMENDATIONS AND POLICIES.—The Collaborative shall make recommendations to identify uniform national policies for adoption by the Federal Government and voluntary adoption by private entities to support

the widespread adoption of health information technology, including—

''(1) protection of individually identifiable health information through privacy and security practices;

''(2) measures to prevent unauthorized access to health information;

''(3) methods to facilitate secure patient access to health information;

''(4) the ongoing harmonization of industry-wide health information technology standards;

''(5) recommendations for a nationwide interoperable health information technology infrastructure;

''(6) the identification and prioritization of specific use cases for which health information technology is valuable, beneficial, and feasible;

''(7) recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and

''(8) other policies determined to be necessary by the Collaborative.

''(d) STANDARDS.—

''(1) EXISTING STANDARDS.—The standards adopted by the Consolidated Health Informatics Ini-

tiative shall be deemed to have been recommended by the Collaborative under this section.

''(2) FIRST YEAR REVIEW.—Not later than 1 year after the date of enactment of this title, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

''(B) identify deficiencies and omissions in such existing standards; and

''(C) identify duplication and overlap in such existing standards;

and recommend modifications to such standards as necessary.

''(3) ONGOING REVIEW.—Beginning 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall—

''(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);

"(B) identify deficiencies and omissions in such existing standards; and

"(C) identify duplication and overlap in such existing standards;

and recommend modifications to such standards as necessary.

"(4) LIMITATION.—The standards described in this section shall be consistent with any standards developed pursuant to the Health Insurance Portability and Accountability Act of 1996.

"(e) FEDERAL ACTION.—Not later than 60 days after the issuance of a recommendation from the Collaborative under subsection (d)(2), the Secretary of Health and Human Services, in consultation with the Secretary of Veterans Affairs, the Secretary of Defense, and representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall review such recommendations. The Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation.

"(f) COORDINATION OF FEDERAL SPENDING.—Not later than 1 year after the adoption by the Federal Government of a recommendation as provided for in subsection (e), and in compliance with chapter 113 of title 40, United States Code, no Federal agency shall expend

Federal funds for the purchase of any form of health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government under subsection (e).

''(g) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in subsection (e), all Federal agencies collecting health data for the purposes of surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary shall comply with standards adopted under subsection (e).

''(h) VOLUNTARY ADOPTION.—

''(1) IN GENERAL.—Any standards adopted by the Federal Government under subsection (e) shall be voluntary with respect to private entities.

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards adopted by the Federal Government under section 2903 with respect to activities not related to the contract.

''(3) LIMITATION.—Private entities that enter into a contract with the Federal Government shall adopt the standards adopted under section 2903 for the purpose of activities under such Federal contract.

''(i) EFFECT ON OTHER PROVISIONS.—Nothing in this title shall be construed to effect the scope or substance of—

''(1) section 264 of the Health Insurance Portability and Accountability Act of 1996;

''(2) sections 1171 through 1179 of the Social Security Act; and

''(3) any regulation issued pursuant to any such section;

and such sections shall remain in effect and shall apply to the implementation of standards, programs and activities under this title.

''(j) REPORTS.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, on an annual basis, a report that—

''(1) describes the specific actions that have been taken by the Federal Government and private

entities to facilitate the adoption of an interoperable nationwide system for the electronic exchange of health information;

''(2) describes barriers to the adoption of such a nationwide system;

''(3) contains recommendations to achieve full implementation of such a nationwide system; and

''(4) contains a plan and progress toward the establishment of an entity to ensure the continuation of the functions of the Collaborative.

''(k) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Collaborative, except that the term provided for under section 14(a)(2) shall be 5 years.

''(l) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Collaborative, regardless of whether such efforts were carried out prior to or after the enactment of this title.

''SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.

''(a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure uniform and consistent im-

plementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

''(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.

''(b) CERTIFICATION.—

''(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware, software, and support services that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintained such compliance in technical conformance with such standards.

''(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.

''(c) DELEGATION AUTHORITY.—The Secretary, through consultation with the Collaborative, may delegate

the development of the criteria under subsections (a) and (b) to a private entity.

"SEC. 2905. STUDY OF STATE HEALTH INFORMATION LAWS AND PRACTICES.

"(a) IN GENERAL.—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—

"(1) the variation among State laws and practices that relate to the privacy, confidentiality, and security of health information;

"(2) how such variation among State laws and practices may impact the electronic exchange of health information—

"(A) among the States;

"(B) between the States and the Federal Government; and

"(C) among private entities; and

"(3) how such laws and practices may be harmonized to permit the secure electronic exchange of health information.

"(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Secretary shall submit to Congress a report that—

"(1) describes the results of the study carried out under subsection (a); and

''(2) makes recommendations based on the results of such study.

"SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION; INCENTIVE GRANTS.

''(a) IN GENERAL.—The Secretary may make grants to States to carry out programs under which such States cooperate with other States to develop and implement State policies that will facilitate the secure electronic exchange of health information utilizing the standards adopted under section 2903—

''(1) among the States;

''(2) between the States and the Federal Government; and

''(3) among private entities.

''(b) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to States that provide assurance that any funding awarded under such a grant shall be used to harmonize privacy laws and practices between the States, the States and the Federal Government, and among private entities related to the privacy, confidentiality, and security of health information.

''(c) DISSEMINATION OF INFORMATION.—The Secretary shall disseminate information regarding the efficacy of efforts of a recipient of a grant under this section.

''(d) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of a grant under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2006 through 2010.

''SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION.

''(a) IN GENERAL.—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—

''(1) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and

''(2) how such variation among State laws impacts the secure electronic exchange of health information—

''(A) among the States; and

''(B) between the States and the Federal Government.

''(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Secretary shall publish a report that—

''(1) describes the results of the study carried out under subsection (a); and

''(2) makes recommendations to States regarding the harmonization of State laws based on the results of such study.

''SEC. 2908. AUTHORIZATION OF APPROPRIATIONS.

''(a) IN GENERAL.—For the purpose of carrying out this title, there is authorized to be appropriated $125,000,000 for fiscal year 2006, and such sums as may be necessary for each of fiscal years 2007 through 2010.

''(b) AVAILABILITY.—Amounts appropriated under subsection (a) shall remain available through fiscal year 2010.''.

SEC. 122. HIPAA REPORT.

(a) STUDY.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines the integration of the standards adopted under the amendments made by this subtitle with the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) PLAN; REPORT.—

(1) PLAN.—Not later than 3 years after the date of enactment of this Act, the Secretary of

Health and Human Services shall, based on the results of the study carried out under subsection (a), develop a plan for the integration of the standards described under such subsection and submit a report to Congress describing such plan.

(2) PERIODIC REPORTS.—The Secretary shall submit periodic reports to Congress that describe the progress of the integration described under paragraph (1).

SEC. 123. STUDY OF REIMBURSEMENT INCENTIVES.

The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.

SEC. 124. REAUTHORIZATION OF INCENTIVE GRANTS REGARDING TELEMEDICINE.

Section 330L(b) of the Public Health Service Act (42 U.S.C. 254c–18(b)) is amended by striking ''2002 through 2006'' and inserting ''2006 through 2010''.

SEC. 125. SENSE OF THE SENATE ON PHYSICIAN PAYMENT.

It is the sense of the Senate that modifications to the medicare fee schedule for physicians' services under section 1848 of the Social Security Act (42 U.S.C.

1394w–4) should include provisions based on the reporting of quality measures pursuant to those adopted in section 2909 of the Public Health Service Act (as added by section 121) and the overall improvement of healthcare quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 2903 of such Act (as added by section 121).

SEC. 126. ESTABLISHMENT OF QUALITY MEASUREMENT SYSTEMS FOR MEDICARE VALUE-BASED PURCHASING PROGRAMS.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

''PART E—VALUE-BASED PURCHASING

''QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED PURCHASING PROGRAMS

''SEC. 1860E–1. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall develop quality measurement systems for purposes of providing value-based payments to—

''(A) hospitals pursuant to section 1860E–2;

''(B) physicians and practitioners pursuant to section 1860E–3;

''(C) plans pursuant to section 1860E–4;

''(D) end stage renal disease providers and facilities pursuant to section 1860E–5; and

''(E) home health agencies pursuant to section 1860E–6.

''(2) QUALITY.—The systems developed under paragraph (1) shall measure the quality of the care furnished by the provider involved.

''(3) HIGH QUALITY HEALTH CARE DEFINED.—In this part, the term 'high quality health care' means health care that is safe, effective, patient-centered, timely, equitable, efficient, necessary, and appropriate.

''(b) REQUIREMENTS FOR SYSTEMS.—Under each quality measurement system described in subsection (a)(1), the Secretary shall do the following:

''(1) MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall select measures of quality to be used by the Secretary under each system.

''(B) REQUIREMENTS.—In selecting the measures to be used under each system pursu-

ant to subparagraph (A), the Secretary shall, to the extent feasible, ensure that—

"(i) such measures are evidence-based, reliable and valid, and feasible to collect and report;

"(ii) measures of process, structure, outcomes, beneficiary experience, efficiency, and equity are included;

"(iii) measures of overuse and underuse of health care items and services are included;

"(iv)(I) at least 1 measure of health information technology infrastructure that enables the provision of high quality health care and facilitates the exchange of health information, such as the use of one or more elements of a qualified health information system (as defined in subparagraph (E)), is included during the first year each system is implemented; and

"(II) additional measures of health information technology infrastructure are included in subsequent years;

"(v) in the case of the system that is used to provide value-based payments to

hospitals under section 1860E–2, by not later than January 1, 2008, at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas are included; and

''(vi) measures that assess the quality of care furnished to frail individuals over the age of 75 and to individuals with multiple complex chronic conditions are included.

''(C) REQUIREMENT FOR COLLECTION OF DATA ON A MEASURE FOR 1 YEAR PRIOR TO USE UNDER THE SYSTEMS.—Data on any measure selected by the Secretary under subparagraph (A) must be collected by the Secretary for at least a 12-month period before such measure may be used to determine whether a provider receives a value-based payment under a program described in subsection (a)(1).

''(D) AUTHORITY TO VARY MEASURES.—

''(i) UNDER SYSTEM APPLICABLE TO HOSPITALS.—In the case of the system applicable to hospitals under section 1860E–2, the Secretary may vary the measures se-

lected under subparagraph (A) by hospital depending on the size of, and the scope of services provided by, the hospital.

"(ii) UNDER SYSTEM APPLICABLE TO PHYSICIANS AND PRACTITIONERS.—In the case of the system applicable to physicians and practitioners under section 1860E–3, the Secretary may vary the measures selected under subparagraph (A) by physician or practitioner depending on the specialty of the physician, the type of practitioner, or the volume of services furnished to beneficiaries by the physician or practitioner.

"(iii) UNDER SYSTEM APPLICABLE TO ESRD PROVIDERS AND FACILITIES.—In the case of the system applicable to providers of services and renal dialysis facilities under section 1860E–5, the Secretary may vary the measures selected under subparagraph (A) by provider or facility depending on the type of, the size of, and the scope of services provided by, the provider or facility.

''(iv) UNDER SYSTEM APPLICABLE TO HOME HEALTH AGENCIES.—In the case of the system applicable to home health agencies under section 1860E–6, the Secretary may vary the measures selected under subparagraph (A) by agency depending on the size of, and the scope of services provided by, the agency.

''(E) QUALIFIED HEALTH INFORMATION SYSTEM DEFINED.—For purposes of subparagraph (B)(iv)(I), the term 'qualified health information system' means a computerized system (including hardware, software, and training) that—

''(i) protects the privacy and security of health information and properly encrypts such health information;

''(ii) maintains and provides access to patients' health records in an electronic format;

''(iii) incorporates decision support software to reduce medical errors and enhance health care quality;

''(iv) is consistent with data standards and certification processes recommended by the Secretary;

''(v) allows for the reporting of quality measures; and

''(vi) includes other features determined appropriate by the Secretary.

''(2) WEIGHTS OF MEASURES.—

''(A) IN GENERAL.—The Secretary shall assign weights to the measures used by the Secretary under each system.

''(B) CONSIDERATION.—If the Secretary determines appropriate, in assigning the weights under subparagraph (A)—

''(i) measures of clinical effectiveness shall be weighted more heavily than measures of beneficiary experience; and

''(ii) measures of risk adjusted outcomes shall be weighted more heavily than measures of process; and

''(3) RISK ADJUSTMENT.—The Secretary shall establish procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics. To the extent feasible, such

procedures may be based on existing models for controlling for such differences.

''(4) MAINTENANCE.—

''(A) IN GENERAL.—The Secretary shall, as determined appropriate, but not more often than once each 12-month period, update each system, including through—

''(i) the addition of more accurate and precise measures under the systems and the retirement of existing outdated measures under the system;

''(ii) the refinement of the weights assigned to measures under the system; and

''(iii) the refinement of the risk adjustment procedures established pursuant to paragraph (3) under the system.

''(B) UPDATE SHALL ALLOW FOR COMPARISON OF DATA.—Each update under subparagraph (A) of a quality measurement system shall allow for the comparison of data from one year to the next for purposes of providing value-based payments under the programs described in subsection (a)(1).

''(5) USE OF MOST RECENT QUALITY DATA.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall use the most recent quality data with respect to the provider involved that is available to the Secretary.

''(B) INSUFFICIENT DATA DUE TO LOW VOLUME.—If the Secretary determines that there is insufficient data with respect to a measure or measures because of a low number of services provided, the Secretary may aggregate data across more than 1 fiscal or calendar year, as the case may be.

''(c) REQUIREMENTS FOR DEVELOPING AND UPDATING THE SYSTEMS.—In developing and updating each quality measurement system under this section, the Secretary shall—

''(1) take into account the quality measures developed by nationally recognized quality measurement organizations, researchers, health care provider organizations, and other appropriate groups;

''(2) consult with, and take into account the recommendations of, the entity that the Secretary has an arrangement with under subsection (e);

''(3) consult with provider-based groups and clinical specialty societies;

''(4) take into account existing quality measurement systems that have been developed through a rigorous process of validation and with the involvement of entities and persons described in subsection (e)(2)(B); and

''(5) take into account—

''(A) each of the reports by the Medicare Payment Advisory Commission that are required under the Medicare Value Purchasing Act of 2005;

''(B) the results of—

''(i) the demonstrations required under such Act;

''(ii) the demonstration program under section 1866A;

''(iii) the demonstration program under section 1866C; and

''(iv) any other demonstration or pilot program conducted by the Secretary relating to measuring and rewarding quality and efficiency of care; and

''(C) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription

Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173).

''(d) REQUIREMENTS FOR IMPLEMENTING THE SYSTEMS.—In implementing each quality measurement system under this section, the Secretary shall consult with entities—

''(1) that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures; and

''(2) that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care.

''(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—

''(1) ARRANGEMENT.—On and after July 1, 2006, the Secretary shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretary with advice on, and recommendations with respect to, the development and updating of the quality measurement systems under

this section, including the assigning of weights to the measures under subsection (b)(2).

''(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:

''(A) The entity is a private nonprofit entity governed by an executive director and a board.

''(B) The members of the entity include representatives of—

''(i)(I) health plans and providers receiving reimbursement under this title for the provision of items and services, including health plans and providers with experience in the care of the frail elderly and individuals with multiple complex chronic conditions; or

''(II) groups representing such health plans and providers;

''(ii) groups representing individuals receiving benefits under this title;

''(iii) purchasers and employers or groups representing purchasers or employers;

''(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;

''(v) State government health programs;

''(vi) persons skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

''(vii) persons or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

''(C) The membership of the entity is representative of individuals with experience with—

''(i) urban health care issues;

''(ii) safety net health care issues; and

''(iii) rural and frontier health care issues.

''(D) The entity does not charge a fee for membership for participation in the work of the

entity related to the arrangement with the Secretary under paragraph (1). If the entity does require a fee for membership for participation in other functions of the entity, there shall be no linkage between such fee and participation in the work of the entity related to such arrangement with the Secretary.

''(E) The entity—

''(i) permits any member described in subparagraph (B) to vote on matters of the entity related to the arrangement with the Secretary under paragraph (1); and

''(ii) ensures that such members have an equal vote on such matters .

''(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular

A–119 (published in the Federal Register on February 10, 1998).''.

(b) CONFORMING REFERENCES TO PREVIOUS PART E.—Any reference in law (in effect before the date of the enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

SEC. 127. EXCEPTION TO FEDERAL ANTI-KICKBACK AND PHYSICIAN SELF REFERRAL LAWS FOR THE PROVISION OF PERMITTED SUPPORT.

(a) ANTI-KICKBACK.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in paragraph (3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in subparagraph (H), as added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) by redesignating subparagraph (H), as added by section 431(a) of the Medicare Pre-

scription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2287), as subparagraph (I);

(D) in subparagraph (I), as so redesignated—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new:

''(J) during the 5-year period beginning on the date the Secretary issues the interim final rule under section 801(c)(1) of the Medicare Value Purchasing Act of 2005, the provision, with or without charge, of any permitted support (as defined in paragraph (4)).''; and

(2) by adding at the end the following new paragraph:

''(4) PERMITTED SUPPORT.—

''(A) DEFINITION OF PERMITTED SUPPORT.—Subject to subparagraph (B), in this section, the term 'permitted support' means the provision of any equipment, item, information, right, license, intellectual property, software,

training, or service used for developing, implementing, operating, or facilitating the use of systems designed to improve the quality of health care and to promote the electronic exchange of health information.

''(B) EXCEPTION.—The term 'permitted support' shall not include the provision of—

''(i) any support that is determined in a manner that is related to the volume or value of any referrals or other business generated between the parties for which payment may be made in whole or in part under a Federal health care program;

''(ii) any support that has more than incidental utility or value to the recipient beyond the exchange of health care information; or

''(iii) any health information technology system, product, or service that is not capable of exchanging health care information in compliance with data standards consistent with interoperability.

''(C) DETERMINATION.—In establishing regulations with respect to the requirement

under subparagraph (B)(iii), the Secretary shall take in account—

"(I) whether the health information technology system, product, or service is widely accepted within the industry and whether there is sufficient industry experience to ensure successful implementation of the system, product, or service; and

"(II) whether the health information technology system, product, or service improves quality of care, enhances patient safety, or provides greater administrative efficiencies.".

(b) PHYSICIAN SELF-REFERRAL.—Section 1877(e) (42 U.S.C. 1395nn(e)) is amended by adding at the end the following new paragraph:

"(9) PERMITTED SUPPORT.—During the 5-year period beginning on the date the Secretary issues the interim final rule under section 801(c)(1) of the Medicare Value Purchasing Act of 2005, the provision, with or without charge, of any permitted support (as defined in section 1128B(b)(4)).".

(c) REGULATIONS.—In order to carry out the amendments made by this section—

(1) the Secretary shall issue an interim final rule with comment period by not later than the date that is 180 days after the date of enactment of this Act;

(2) the Secretary shall issue a final rule by not later than the date that is 180 days after the date that the interim final rule under paragraph (1) is issued.

CHAPTER 2—VALUE BASED PURCHASING

SEC. 131. VALUE BASED PURCHASING PROGRAMS; SENSE OF THE SENATE.

(a) MEDICARE VALUE BASED PURCHASING PILOT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) a value based purchasing pilot program based on the reporting of quality measures pursuant to those adopted in section 1860E–1 of the Social Security Act (as added by section 126). Such pilot program should be based on experience gained through previous demonstration projects conducted by the Secretary, including demonstration projects conducted under sections 1866A and 1866C of the Social Security Act

(42 U.S.C. 1395cc–1; 1395cc–3), section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2322), and other relevant work conducted by private entities.

(2) EXPANSION.—Not later than 2 years after conducting the pilot program under paragraph (1), the Secretary shall transition and implement such program on a national basis.

(3) INFORMATION TECHNOLOGY.—Providers reporting quality measurement data electronically under this section shall report such data pursuant to the standards adopted under title XXIX of the Public Health Service Act (as added by section 121).

(4) FUNDING.—The Secretary shall ensure that the total amount of expenditures under this Act in a year does not exceed the total amount of expenditures that would have been expended in such year under this Act if this subsection had not been enacted.

(b) MEDICAID VALUE BASED PURCHASING PROGRAMS.—

(1) IN GENERAL.—The Secretary shall authorize waivers under section 1115 of the Social Security Act (42 U.S.C. 1315) for States to establish value

based purchasing programs for State medicaid programs established under title XIX of such Act (42 U.S.C. 1396 et seq.). Such programs shall be based on the reporting of quality measures pursuant to those adopted in section 1860E–1 of the Social Security Act (as added by section 126).

(2) INFORMATION TECHNOLOGY.—Providers reporting quality measurement data electronically under this section shall report such data pursuant to the standards adopted under title XXIX of the Public Health Service Act (as added by section 121).

(3) WAIVER.—In authorizing such waivers, the Secretary shall waive any provisions of title XI or XIX of the Social Security Act that would otherwise prevent a State from establishing a value based purchasing program in accordance with paragraph (1).

Subtitle C—Patient Safety and Quality Improvement

SEC. 141. SHORT TITLE.

This subtitle may be cited as the ''Patient Safety and Quality Improvement Act of 2005''.

SEC. 142. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) In 1999, the Institute of Medicine released a report entitled To Err is Human that described medical errors as the eighth leading cause of death in the United States, with as many as 98,000 people dying as a result of medical errors each year.

(2) To address these deaths and injuries due to medical errors, the health care system must identify and learn from such errors so that systems of care can be improved.

(3) In their report, the Institute of Medicine called on Congress to provide legal protections with respect to information reported for the purposes of quality improvement and patient safety.

(4) The Health, Education, Labor, and Pensions Committee of the Senate held 4 hearings in the 106th Congress and 1 hearing in the 107th Congress on patient safety where experts in the field supported the recommendation of the Institute of Medicine for congressional action.

(5) Myriad public and private patient safety initiatives have begun. The Quality Interagency Coordination Taskforce has recommended steps to improve patient safety that may be taken by each Federal agency involved in health care and activities relating to these steps are ongoing.

(6) The research on patient safety unequivocally calls for a learning environment, rather than a punitive environment, in order to improve patient safety.

(7) Voluntary data gathering systems are more supportive than mandatory systems in creating the learning environment referred to in paragraph (6) as stated in the Institute of Medicine's report.

(8) Promising patient safety reporting systems have been established throughout the United States and the best ways to structure and use these systems are currently being determined, largely through projects funded by the Agency for Healthcare Research and Quality.

(9) Many organizations currently collecting patient safety data have expressed a need for legal protections that will allow them to review protected information and collaborate in the development and implementation of patient safety improvement strategies. Currently, the State peer review protections are inadequate to allow the sharing of information to promote patient safety.

(b) PURPOSES.—It is the purpose of this subtitle to—

(1) encourage a culture of safety and quality in the United States health care system by providing for legal protection of information reported voluntarily for the purposes of quality improvement and patient safety; and

(2) ensure accountability by raising standards and expectations for continuous quality improvements in patient safety.

SEC. 143. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) in section 912(c), by inserting ", in accordance with part C," after "The Director shall";

(2) by redesignating part C as part D;

(3) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(4) in 934(d) (as so redesignated), by striking the second sentence and inserting the following: "Penalties provided for under this section shall be imposed and collected by the Secretary using the administrative and procedural processes used to impose and collect civil money penalties under section 1128A of the Social Security Act (other than subsections (a) and (b), the second sentence of subsection (f), and subsections (i), (m), and (n)), unless

the Secretary determines that a modification of procedures would be more suitable or reasonable to carry out this subsection and provides for such modification by regulation.'';

(5) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(6) by inserting after part B the following:

''PART C—PATIENT SAFETY IMPROVEMENT

''SEC. 921. DEFINITIONS.

''In this part:

''(1) NON-IDENTIFIABLE INFORMATION.—

''(A) IN GENERAL.—The term 'non-identifiable information' means, with respect to information, that the information is presented in a form and manner that prevents the identification of a provider, a patient, or a reporter of patient safety data.

''(B) IDENTIFIABILITY OF PATIENT.—For purposes of subparagraph (A), the term 'presented in a form and manner that prevents the identification of a patient' means, with respect to information that has been subject to rules promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), that the

information has been de-identified so that it is no longer individually identifiable health information as defined in such rules.

''(2) PATIENT SAFETY DATA.—

''(A) IN GENERAL.—The term 'patient safety data' means—

''(i) any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements that are—

''(I) collected or developed by a provider for reporting to a patient safety organization, provided that they are reported to the patient safety organization within 60 days;

''(II) requested by a patient safety organization (including the contents of such request), if they are reported to the patient safety organization within 60 days;

''(III) reported to a provider by a patient safety organization; or

''(IV) collected by a patient safety organization from another patient

safety organization, or developed by a patient safety organization;

that could result in improved patient safety, health care quality, or health care outcomes; or

''(ii) any deliberative work or process with respect to any patient safety data described in clause (i).

''(B) LIMITATION.—

''(i) COLLECTION.—If the original material from which any data, reports, records, memoranda, analyses (such as root case analyses), or written or oral statements referred to in subclause (I) or (IV) of subparagraph (A)(i) are collected and is not patient safety data, the act of such collection shall not make such original material patient safety data for purposes of this part.

''(ii) SEPARATE DATA.—The term 'patient safety data' shall not include information (including a patient's medical record, billing and discharge information or any other patient or provider record) that is collected or developed separately

from and that exists separately from patient safety data. Such separate information or a copy thereof submitted to a patient safety organization shall not itself be considered as patient safety data. Nothing in this part, except for section 922(f)(1), shall be construed to limit—

"(I) the discovery of or admissibility of information described in this subparagraph in a criminal, civil, or administrative proceeding;

"(II) the reporting of information described in this subparagraph to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes; or

"(III) a provider's recordkeeping obligation with respect to information described in this subparagraph under Federal, State, or local law.

"(3) PATIENT SAFETY ORGANIZATION.—The term 'patient safety organization' means a private or

public entity or component thereof that is currently listed by the Secretary pursuant to section 924(c).

''(4) PATIENT SAFETY ORGANIZATION ACTIVITIES.—The term 'patient safety organization activities' means the following activities, which are deemed to be necessary for the proper management and administration of a patient safety organization:

''(A) The conduct, as its primary activity, of efforts to improve patient safety and the quality of health care delivery.

''(B) The collection and analysis of patient safety data that are submitted by more than one provider.

''(C) The development and dissemination of information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices.

''(D) The utilization of patient safety data for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk.

''(E) The maintenance of procedures to preserve confidentiality with respect to patient safety data.

''(F) The provision of appropriate security measures with respect to patient safety data.

''(G) The utilization of qualified staff.

''(5) PERSON.—The term 'person' includes Federal, State, and local government agencies.

''(6) PROVIDER.—The term 'provider' means—

''(A) a person licensed or otherwise authorized under State law to provide health care services, including—

''(i) a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, clinical laboratory, or health center; or

''(ii) a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutri-

tion professional, physical or occupational therapist, pharmacist, or other individual health care practitioner; or

''(B) any other person specified in regulations promulgated by the Secretary.

''SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTECTIONS.

''(a) PRIVILEGE.—Notwithstanding any other provision of Federal, State, or local law, patient safety data shall be privileged and, subject to the provisions of subsection (c)(1), shall not be—

''(1) subject to a Federal, State, or local civil, criminal, or administrative subpoena;

''(2) subject to discovery in connection with a Federal, State, or local civil, criminal, or administrative proceeding;

''(3) disclosed pursuant to section 552 of title 5, United States Code (commonly known as the Freedom of Information Act) or any other similar Federal, State, or local law;

''(4) admitted as evidence or otherwise disclosed in any Federal, State, or local civil, criminal, or administrative proceeding; or

''(5) utilized in a disciplinary proceeding against a provider.

''(b) CONFIDENTIALITY.—Notwithstanding any other provision of Federal, State, or local law, and subject to the provisions of subsections (c) and (d), patient safety data shall be confidential and shall not be disclosed.

''(c) EXCEPTIONS TO PRIVILEGE AND CONFIDENTIALITY.—Nothing in this section shall be construed to prohibit one or more of the following uses or disclosures:

''(1) Disclosure by a provider or patient safety organization of relevant patient safety data for use in a criminal proceeding only after a court makes an in camera determination that such patient safety data contains evidence of a wanton and criminal act to directly harm the patient.

''(2) Voluntary disclosure of non-identifiable patient safety data by a provider or a patient safety organization.

''(d) PROTECTED DISCLOSURE AND USE OF INFORMATION.—Nothing in this section shall be construed to prohibit one or more of the following uses or disclosures:

''(1) Disclosure of patient safety data by a person that is a provider, a patient safety organization, or a contractor of a provider or patient safety organization, to another such person, to carry out patient safety organization activities.

''(2) Disclosure of patient safety data by a provider or patient safety organization to grantees or contractors carrying out patient safety research, evaluation, or demonstration projects authorized by the Director.

''(3) Disclosure of patient safety data by a provider to an accrediting body that accredits that provider.

''(4) Voluntary disclosure of patient safety data by a patient safety organization to the Secretary for public health surveillance if the consent of each provider identified in, or providing, such data is obtained prior to such disclosure. Nothing in the preceding sentence shall be construed to prevent the release of patient safety data that is provided by, or that relates solely to, a provider from which the consent described in such sentence is obtained because one or more other providers do not provide such consent with respect to the disclosure of patient safety date that relates to such nonconsenting providers. Consent for the future release of patient safety data for such purposes may be requested by the patient safety organization at the time the data is submitted.

''(5) Voluntary disclosure of patient safety data by a patient safety organization to State of local government agencies for public health surveillance if the consent of each provider identified in, or providing, such data is obtained prior to such disclosure. Nothing in the preceding sentence shall be construed to prevent the release of patient safety data that is provided by, or that relates solely to, a provider from which the consent described in such sentence is obtained because one or more other providers do not provide such consent with respect to the disclosure of patient safety date that relates to such nonconsenting providers. Consent for the future release of patient safety data for such purposes may be requested by the patient safety organization at the time the data is submitted.

''(e) CONTINUED PROTECTION OF INFORMATION AFTER DISCLOSURE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), patient safety data that is used or disclosed shall continue to be privileged and confidential as provided for in subsections (a) and (b), and the provisions of such subsections shall apply to such data in the possession or control of—

''(A) a provider or patient safety organization that possessed such data before the use or disclosure; or

''(B) a person to whom such data was disclosed.

''(2) EXCEPTION.—Notwithstanding paragraph (1), and subject to paragraph (3)—

''(A) if patient safety data is used or disclosed as provided for in subsection (c)(1), and such use or disclosure is in open court, the confidentiality protections provided for in subsection (b) shall no longer apply to such data; and

''(B) if patient safety data is used or disclosed as provided for in subsection (c)(2), the privilege and confidentiality protections provided for in subsections (a) and (b) shall no longer apply to such data.

''(3) CONSTRUCTION.—Paragraph (2) shall not be construed as terminating or limiting the privilege or confidentiality protections provided for in subsection (a) or (b) with respect to data other than the specific data used or disclosed as provided for in subsection (c).

''(f) LIMITATION ON ACTIONS.—

''(1) PATIENT SAFETY ORGANIZATIONS.—Except to enforce disclosures pursuant to subsection (c)(1), no action may be brought or process served against a patient safety organization to compel disclosure of information collected or developed under this part whether or not such information is patient safety data unless such information is specifically identified, is not patient safety data, and cannot otherwise be obtained.

''(2) PROVIDERS.—An accrediting body shall not take an accrediting action against a provider based on the good faith participation of the provider in the collection, development, reporting, or maintenance of patient safety data in accordance with this part. An accrediting body may not require a provider to reveal its communications with any patient safety organization established in accordance with this part.

''(g) REPORTER PROTECTION.—

''(1) IN GENERAL.—A provider may not take an adverse employment action, as described in paragraph (2), against an individual based upon the fact that the individual in good faith reported information—

''(A) to the provider with the intention of having the information reported to a patient safety organization; or

''(B) directly to a patient safety organization.

''(2) ADVERSE EMPLOYMENT ACTION.—For purposes of this subsection, an 'adverse employment action' includes—

''(A) loss of employment, the failure to promote an individual, or the failure to provide any other employment-related benefit for which the individual would otherwise be eligible; or

''(B) an adverse evaluation or decision made in relation to accreditation, certification, credentialing, or licensing of the individual.

''(h) ENFORCEMENT.—

''(1) PROHIBITION.—Except as provided in subsections (c) and (d) and as otherwise provided for in this section, it shall be unlawful for any person to negligently or intentionally disclose any patient safety data, and any such person shall, upon adjudication, be assessed in accordance with section 934(d).

''(2) RELATION TO HIPAA.—The penalty provided for under paragraph (1) shall not apply if the defendant would otherwise be subject to a penalty

under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) or under section 1176 of the Social Security Act (42 U.S.C. 1320d–5) for the same disclosure.

''(3) EQUITABLE RELIEF.—

''(A) IN GENERAL.—Without limiting remedies available to other parties, a civil action may be brought by any aggrieved individual to enjoin any act or practice that violates subsection (g) and to obtain other appropriate equitable relief (including reinstatement, back pay, and restoration of benefits) to redress such violation.

''(B) AGAINST STATE EMPLOYEES.—An entity that is a State or an agency of a State government may not assert the privilege described in subsection (a) unless before the time of the assertion, the entity or, in the case of and with respect to an agency, the State has consented to be subject to an action as described by this paragraph, and that consent has remained in effect.

''(i) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to—

''(1) limit other privileges that are available under Federal, State, or local laws that provide greater confidentiality protections or privileges than the privilege and confidentiality protections provided for in this section;

''(2) limit, alter, or affect the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under this section;

''(3) alter or affect the implementation of any provision of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), section 1176 of the Social Security Act (42 U.S.C. 1320d–5), or any regulation promulgated under such sections;

''(4) limit the authority of any provider, patient safety organization, or other person to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with subsection (c) or (d); and

''(5) prohibit a provider from reporting a crime to law enforcement authorities, regardless of whether knowledge of the existence of, or the description of, the crime is based on patient safety data, so long as

the provider does not disclose patient safety data in making such report.

"SEC. 923. PATIENT SAFETY NETWORK OF DATABASES.

"(a) IN GENERAL.—The Secretary shall maintain a patient safety network of databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other persons. The network of databases shall have the capacity to accept, aggregate, and analyze nonidentifiable patient safety data voluntarily reported by patient safety organizations, providers, or other persons.

"(b) NETWORK OF DATABASE STANDARDS.—The Secretary may determine common formats for the reporting to the patient safety network of databases maintained under subsection (a) of nonidentifiable patient safety data, including necessary data elements, common and consistent definitions, and a standardized computer interface for the processing of such data. To the extent practicable, such standards shall be consistent with the administrative simplification provisions of Part C of title XI of the Social Security Act.

"SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFICATION AND LISTING.

"(a) CERTIFICATION.—

''(1) INITIAL CERTIFICATION.—Except as provided in paragraph (2), an entity that seeks to be a patient safety organization shall submit an initial certification to the Secretary that the entity intends to perform the patient safety organization activities.

''(2) DELAYED CERTIFICATION OF COLLECTION FROM MORE THAN ONE PROVIDER.—An entity that seeks to be a patient safety organization may—

''(A) submit an initial certification that it intends to perform patient safety organization activities other than the activities described in subparagraph (B) of section 921(4); and

''(B) within 2 years of submitting the initial certification under subparagraph (A), submit a supplemental certification that it performs the patient safety organization activities described in subparagraphs (A) through (F) of section 921(4).

''(3) EXPIRATION AND RENEWAL.—

''(A) EXPIRATION.—An initial certification under paragraph (1) or (2)(A) shall expire on the date that is 3 years after it is submitted.

''(B) RENEWAL.—

''(i) IN GENERAL.—An entity that seeks to remain a patient safety organiza-

tion after the expiration of an initial certification under paragraph (1) or (2)(A) shall, within the 3-year period described in subparagraph (A), submit a renewal certification to the Secretary that the entity performs the patient safety organization activities described in section 921(4).

''(ii) TERM OF RENEWAL.—A renewal certification under clause (i) shall expire on the date that is 3 years after the date on which it is submitted, and may be renewed in the same manner as an initial certification.

''(b) ACCEPTANCE OF CERTIFICATION.—Upon the submission by an organization of an initial certification pursuant to subsection (a)(1) or (a)(2)(A), a supplemental certification pursuant to subsection (a)(2)(B), or a renewal certification pursuant to subsection (a)(3)(B), the Secretary shall review such certification and—

''(1) if such certification meets the requirements of subsection (a)(1), (a)(2)(A), (a)(2)(B), or (a)(3)(B), as applicable, the Secretary shall notify the organization that such certification is accepted; or

''(2) if such certification does not meet such requirements, as applicable, the Secretary shall notify the organization that such certification is not accepted and the reasons therefor.

''(c) LISTING.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the Secretary shall compile and maintain a current listing of patient safety organizations with respect to which the Secretary has accepted a certification pursuant to subsection (b).

''(2) REMOVAL FROM LISTING.—The Secretary shall remove from the listing under paragraph (1)—

''(A) an entity with respect to which the Secretary has accepted an initial certification pursuant to subsection (a)(2)(A) and which does not submit a supplemental certification pursuant to subsection (a)(2)(B) that is accepted by the Secretary;

''(B) an entity whose certification expires and which does not submit a renewal application that is accepted by the Secretary; and

''(C) an entity with respect to which the Secretary revokes the Secretary's acceptance of the entity's certification, pursuant to subsection (d).

''(d) REVOCATION OF ACCEPTANCE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), if the Secretary determines (through a review of patient safety organization activities) that a patient safety organization does not perform one of the patient safety organization activities described in subparagraph (A) through (F) of section 921(4), the Secretary may, after notice and an opportunity for a hearing, revoke the Secretary's acceptance of the certification of such organization.

''(2) DELAYED CERTIFICATION OF COLLECTION FROM MORE THAN ONE PROVIDER.—A revocation under paragraph (1) may not be based on a determination that the organization does not perform the activity described in section 921(4)(B) if—

''(A) the listing of the organization is based on its submittal of an initial certification under subsection (a)(2)(A);

''(B) the organization has not submitted a supplemental certification under subsection (a)(2)(B); and

''(C) the 2-year period described in subsection (a)(2)(B) has not expired.

''(e) NOTIFICATION OF REVOCATION OR REMOVAL FROM LISTING.—

''(1) SUPPLYING CONFIRMATION OF NOTIFICATION TO PROVIDERS.—Within 15 days of a revocation under subsection (d)(1), a patient safety organization shall submit to the Secretary a confirmation that the organization has taken all reasonable actions to notify each provider whose patient safety data is collected or analyzed by the organization of such revocation.

''(2) PUBLICATION.—Upon the revocation of an acceptance of an organization's certification under subsection (d)(1), or upon the removal of an organization from the listing under subsection (c)(2), the Secretary shall publish notice of the revocation or removal in the Federal Register.

''(f) STATUS OF DATA AFTER REMOVAL FROM LISTING.—

''(1) NEW DATA.—With respect to the privilege and confidentiality protections described in section 922, data submitted to an organization within 30 days after the organization is removed from the listing under subsection (c)(2) shall have the same status as data submitted while the organization was still listed.

''(2) PROTECTION TO CONTINUE TO APPLY.—If the privilege and confidentiality protections de-

scribed in section 922 applied to data while an organization was listed, or during the 30-day period described in paragraph (1), such protections shall continue to apply to such data after the organization is removed from the listing under subsection (c)(2).

''(g) DISPOSITION OF DATA.—If the Secretary removes an organization from the listing as provided for in subsection (c)(2), with respect to the patient safety data that the organization received from providers, the organization shall—

''(1) with the approval of the provider and another patient safety organization, transfer such data to such other organization;

''(2) return such data to the person that submitted the data; or

''(3) if returning such data to such person is not practicable, destroy such data.

''SEC. 925. TECHNICAL ASSISTANCE.

''The Secretary, acting through the Director, may provide technical assistance to patient safety organizations, including convening annual meetings for patient safety organizations to discuss methodology, communication, data collection, or privacy concerns.

"SEC. 926. PROMOTING THE INTEROPERABILITY OF HEALTH CARE INFORMATION TECHNOLOGY SYSTEMS.

''(a) DEVELOPMENT.—Not later than 36 months after the date of enactment of the Patient Safety and Quality Improvement Act of 2005, the Secretary shall develop or adopt voluntary standards that promote the electronic exchange of health care information.

''(b) UPDATES.—The Secretary shall provide for the ongoing review and periodic updating of the standards developed under subsection (a).

''(c) DISSEMINATION.—The Secretary shall provide for the dissemination of the standards developed and updated under this section.

"SEC. 927. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this part.''.

SEC. 144. STUDIES AND REPORTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract (based upon a competitive contracting process) with an appropriate research organization for the conduct of a study to assess the impact of medical technologies and therapies on patient safety, patient benefit, health care quality, and the costs of care as well as productivity growth. Such study shall examine—

(1) the extent to which factors, such as the use of labor and technological advances, have contributed to increases in the share of the gross domestic product that is devoted to health care and the impact of medical technologies and therapies on such increases;

(2) the extent to which early and appropriate introduction and integration of innovative medical technologies and therapies may affect the overall productivity and quality of the health care delivery systems of the United States; and

(3) the relationship of such medical technologies and therapies to patient safety, patient benefit, health care quality, and cost of care.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report containing the results of the study conducted under subsection (a).

Subtitle D—Fraud and Abuse

SEC. 151. NATIONAL EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PILOT PROGRAM.

(a) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following:

"(6) The Medicare-Medicaid data match program in accordance with subsection (g)."; and

(2) by adding at the end the following:

"(g) MEDICARE-MEDICAID DATA MATCH PROGRAM.—

"(1) EXPANSION OF PROGRAM.—

"(A) IN GENERAL.—The Secretary shall enter into contracts with eligible entities for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid data match program (commonly referred to as the 'Medi-Medi Program') is conducted with respect to the program established under this title and the applicable number of State Medicaid programs under title XIX for the purpose of—

"(i) identifying vulnerabilities in both such programs;

"(ii) assisting States, as appropriate, to take action to protect the Federal share of expenditures under the Medicaid program; and

"(iii) increasing the effectiveness and efficiency of both such programs through

cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures.

''(B) APPLICABLE NUMBER.—For purposes of subparagraph (A), the term 'applicable number' means—

''(i) in the case of fiscal year 2006, 10 State Medicaid programs;

''(ii) in the case of fiscal year 2007, 12 State Medicaid programs; and

''(iii) in the case of fiscal year 2008, 15 State Medicaid programs.

''(2) LIMITED WAIVER AUTHORITY.—The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).''.

(b) FUNDING.—Section 1817(k)(4) of the Social Security Act (42 U.S.C. 1395i(k)(4)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(2) by adding at the end the following:

''(C) EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM.—Of the amount appropriated under subparagraph (A) for a fis-

cal year, the following amounts shall be used to carry out section 1893(b)(6) for that year:

''(i) $10,000,000 of the amount appropriated for fiscal year 2006.

''(ii) $12,200,000 of the amount appropriated for fiscal year 2007.

''(iii) $15,800,000 of the amount appropriated for fiscal year 2008.''.

Subtitle E—Miscellaneous Provisions

SEC. 161. SENSE OF THE SENATE ON ESTABLISHING A MANDATED BENEFITS COMMISSION.

It is the sense of the Senate that—

(1) there should be established an independent Federal entity to study and provide advice to Congress on existing and proposed federally mandated health insurance benefits offered by employer-sponsored health plans and insurance issuers; and

(2) advice provided under paragraph (1) should be evidence- and actuarially-based, and take into consideration the population costs and benefits, including the health, financial, and social impact on affected populations, safety and medical efficacy, the impact on costs and access to insurance generally, and to different types of insurance products, the im-

pact on labor costs and jobs, and any other relevant factors.

SEC. 162. ENFORCEMENT OF REIMBURSEMENT PROVISIONS BY FIDUCIARIES.

Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(3)) is amended by inserting before the semicolon the following: ''(which may include the recovery of amounts on behalf of the plan by a fiduciary enforcing the terms of the plan that provide a right of recovery by reimbursement or subrogation with respect to benefits provided to a participant or beneficiary)''.

TITLE II—EXPANDING ACCESS TO AFFORDABLE HEALTH COVERAGE THROUGH TAX INCENTIVES AND OTHER INITIATIVES

Subtitle A—Refundable Health Insurance Credit

SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CREDIT.

(a) ALLOWANCE OF CREDIT.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is

amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED INDIVIDUALS.

"(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the amount paid by the taxpayer during such taxable year for qualified health insurance for the taxpayer and the taxpayer's spouse and dependents.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the lesser of—

"(A) 90 percent of the sum of the amounts paid by the taxpayer for qualified health insurance for each individual referred to in subsection (a) for coverage months of the individual during the taxable year, or

"(B) $3,000.

"(2) MONTHLY LIMITATION.—

"(A) IN GENERAL.—For purposes of paragraph (1), amounts paid by the taxpayer for

qualified health insurance for an individual for any coverage month of such individual during the taxable year shall not be taken into account to the extent such amounts exceed the amount equal to 1/12 of—

''(i) $1,111 if such individual is the taxpayer,

''(ii) $1,111 if—

''(I) such individual is the spouse of the taxpayer,

''(II) the taxpayer and such spouse are married as of the first day of such month, and

''(III) the taxpayer files a joint return for the taxable year,

''(iii) $1,111 if such individual has attained the age of 24 as of the close of the taxable year and is a dependent of the taxpayer for such taxable year, and

''(iv) one-half of the amount described in clause (i) if such individual has not attained the age of 24 as of the close of the taxable year and is a dependent of the taxpayer for such taxable year.

''(B) LIMITATION TO 2 YOUNG DEPENDENTS.—If there are more than 2 individuals described in subparagraph (A)(iv) with respect to the taxpayer for any coverage month, the aggregate amounts paid by the taxpayer for qualified health insurance for such individuals which may be taken into account under paragraph (1) shall not exceed 1/12 of the dollar amount in effect under subparagraph (A)(i) for the coverage month.

''(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of a taxpayer—

''(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

''(ii) who does not live apart from such taxpayer's spouse at all times during the taxable year,

any dollar limitation imposed under this paragraph on amounts paid for qualified health insurance for individuals described in subparagraph (A)(iv) shall be divided equally between the taxpayer and the taxpayer's spouse unless they agree on a different division.

''(3) INCOME PHASEOUT OF CREDIT PERCENTAGE FOR ONE-PERSON COVERAGE.—

''(A) PHASEOUT FOR UNMARRIED INDIVIDUALS (OTHER THAN SURVIVING SPOUSES AND HEADS OF HOUSEHOLDS).—In the case of an individual (other than a surviving spouse, the head of a household, or a married individual) with one-person coverage, if such individual has modified adjusted gross income—

''(i) in excess of $15,000 for a taxable year but not in excess of $20,000, the 90 percent under paragraph (1)(B) shall be reduced by the number of percentage points which bears the same ratio to 40 percentage points as—

''(I) the excess of modified adjusted gross income in excess of $15,000, bears to

''(II) $5,000, or

''(ii) in excess of $20,000 for a taxable year, the 90 percent under paragraph (1)(B) shall be reduced by the sum of 40 percentage points plus the number of percentage points which bears the same ratio to 50 percentage points as—

"(I) the excess of modified adjusted gross income in excess of $20,000, bears to

"(II) $10,000.

"(B) PHASEOUT FOR OTHER INDIVIDUALS.—In the case of a taxpayer (other than an individual described in subparagraph (A) or (C)) with one-person coverage, if the taxpayer has modified adjusted gross income in excess of $25,000 for a taxable year, the 90 percent under paragraph (1)(B) shall be reduced by the number of percentage points which bears the same ratio to 90 percentage points as—

"(i) the excess of modified adjusted gross income in excess of $25,000, bears to

"(ii) $15,000.

"(C) MARRIED FILING SEPARATE RETURN.—In the case of a taxpayer who is married filing a separate return for the taxable year and who has one-person coverage, if the taxpayer has modified adjusted gross income in excess of $12,500 for the taxable year, the 90 percent under paragraph (1)(B) shall be reduced by the number of percentage points

which bears the same ratio to 90 percentage points as—

"(i) the excess of modified adjusted gross income in excess of $12,500, bears to

"(ii) $7,500.

"(4) INCOME PHASEOUT OF CREDIT PERCENTAGE FOR COVERAGE OF MORE THAN ONE PERSON.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of a taxpayer with coverage of more than one person, if the taxpayer has modified adjusted gross income in excess of $25,000 for a taxable year, the 90 percent under paragraph (1)(B) shall be reduced by the number of percentage points which bears the same ratio to 90 percentage points as—

"(i) the excess of modified adjusted gross income in excess of $25,000, bears to

"(ii) $35,000.

"(B) MARRIED FILING SEPARATE RETURN.—In the case of a taxpayer who is married filing a separate return for the taxable year and who has coverage of more than one person, if the taxpayer has modified adjusted gross income in excess of $12,500 for the taxable year,

the 90 percent under paragraph (1)(B) shall be reduced by the number of percentage points which bears the same ratio to 90 percentage points as—

"(i) the excess of modified adjusted gross income in excess of $12,500, bears to

"(ii) $17,500.

"(5) ROUNDING.—Any percentage resulting from a reduction under paragraphs (3) and (4) shall be rounded to the nearest one-tenth of a percent.

"(6) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined—

"(A) without regard to this section and sections 911, 931, and 933, and

"(B) after application of sections 86, 135, 137, 219, 221, and 469.

"(c) COVERAGE MONTH.—For purposes of this section—

"(1) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

"(A) as of the first day of such month such individual is covered by qualified health insurance, and

''(B) the premium for coverage under such insurance for such month is paid by the taxpayer.

''(2) GROUP HEALTH PLAN COVERAGE.—

''(A) IN GENERAL.—The term 'coverage month' shall not include any month for which if, as of the first day of the month, the individual participates in any group health plan (within the meaning of section 5000 without regard to section 5000(d)).

''(B) EXCEPTION FOR CERTAIN PERMITTED COVERAGE.—Subparagraph (A) shall not apply to an individual if the individual's only coverage for a month is coverage described in clause (i) or (ii) of section 223(c)(1)(B).

''(3) EMPLOYER-PROVIDED COVERAGE.—The term 'coverage month' shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 (other than coverage described in clause (i) or (ii) of section 223(c)(1)(B)).

''(4) MEDICARE, MEDICAID, AND SCHIP.—The term 'coverage month' shall not include any month with respect to an individual if, as of the first day of such month, such individual—

"(A) is entitled to any benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

"(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

"(5) CERTAIN OTHER COVERAGE.—The term 'coverage month' shall not include any month during a taxable year with respect to an individual if, as of the first day of such month at any time during such month, such individual is enrolled in a program under—

"(A) chapter 89 of title 5, United States Code, or

"(B) chapter 55 of title 10, United States Code.

"(6) PRISONERS.—The term 'coverage month' shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

"(7) INSUFFICIENT PRESENCE IN UNITED STATES.—The term 'coverage month' shall not include any month during a taxable year with respect to an individual if such individual is present in the

United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(d) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means health insurance coverage (as defined in section 9832(b)(1)) which—

''(A) is coverage described in paragraph (2), and

''(B) meets the requirements of paragraph (3).

''(2) ELIGIBLE COVERAGE.—Coverage described in this paragraph is the following:

''(A) Coverage under individual health insurance.

''(B) Coverage through a private sector health care coverage purchasing pool.

''(C) Coverage through a State care coverage purchasing pool.

''(D) Coverage under a State high-risk pool described in subparagraph (C) of section 35(e)(1).

''(E) Coverage after December 31, 2006, under an eligible State buy in program.

''(3) REQUIREMENTS.—The requirements of this paragraph are as follows:

''(A) COST LIMITS.—The coverage meets the requirements of section 223(c)(2)(A)(ii).

''(B) MAXIMUM BENEFITS.—Under the coverage, the annual and lifetime maximum benefits are not less than $700,000.

''(C) BROAD COVERAGE.—The coverage includes inpatient and outpatient care, emergency benefits, and physician care.

''(D) GUARANTEED RENEWABILITY.—Such coverage is guaranteed renewable by the provider.

''(4) ELIGIBLE STATE BUY IN PROGRAM.—For purposes of paragraph (2)(E)—

''(A) IN GENERAL.—The term 'eligible State buy in program' means a State program under which an individual who—

''(i) is not eligible for assistance under the State medicaid program under title XIX of the Social Security Act,

''(ii) is not eligible for assistance under the State children's health insurance program under title XXI of such Act, or

''(iii) is not a State employee,

is able to buy health insurance coverage through a purchasing arrangement entered into between the State and a private sector health care purchasing group or health plan.

''(B) REQUIREMENTS.—Subparagraph (A) shall only apply to a State program if—

''(i) the program uses private sector health care purchasing groups or health plans, and

''(ii) the State maintains separate risk pools for participants under the State buy in program and other participants.

''(C) SUBSIDIES.—

''(i) IN GENERAL.—A State program shall not fail to be treated as an eligible State buy in program merely because the State subsidizes the costs of an individual in buying health insurance coverage under the program.

''(ii) EXCEPTION.—Clause (i) shall not apply if the State subsidy under the program for any adult for any consecutive 12-month period exceeds the applicable dollar amount.

"(iii) APPLICABLE DOLLAR AMOUNT.—

"(I) IN GENERAL.—For purposes of clause (ii), the applicable dollar amount is $2,000.

"(II) REDUCTION.—In the case of a family with annual income in excess of 133 percent of the applicable poverty line (as determined in accordance with criteria established by the Director of the Office of Management and Budget) but not in excess of 200 percent of such line, the dollar amount under clause (i) shall be ratably reduced (but not below zero) for each dollar of such excess. In the case of a family with annual income in excess of 200 percent of such line, the applicable dollar amount shall be zero.

"(e) ARRANGEMENTS UNDER WHICH INSURERS CONTRIBUTE TO HSA.—

"(1) IN GENERAL.—For purposes of this section, health insurance shall not be treated as qualified health insurance if the insurer makes contributions to a health savings account of the taxpayer un-

less such insurance is provided under an arrangement described in paragraph (2).

''(2) ARRANGEMENTS DESCRIBED.—

''(A) AMOUNTS PAID FOR COVERAGE EXCEED MONTHLY LIMITATION.—In the case of amounts paid under an arrangement for health insurance for a coverage month in excess of the amount in effect under subsection (b)(2)(A) for such month, an arrangement is described in this subparagraph if under the arrangement—

''(i) the aggregate amount contributed by the insurer to any health savings account of the taxpayer does not exceed 90 percent of the excess of—

''(I) the amount paid by the taxpayer for qualified health insurance under such arrangement for such month, over

''(II) the amount in effect under subsection (b)(2)(A) for such month, and

''(ii) the amount contributed by the insurer to a qualified health savings account of the taxpayer, reduced by the amount of the excess under clause (i), does

not exceed 27 percent of the amount in effect under subsection (b)(2)(A) for such month.

''(B) AMOUNTS PAID FOR COVERAGE LESS THAN MONTHLY LIMITATION.—In the case of an arrangement under which the amount paid for qualified health insurance for a coverage month does not exceed the amount in effect under subsection (b)(2)(A) for such month, an arrangement is described in this subparagraph if—

''(i) under the arrangement the value of the insured benefits (excluding overhead) exceeds 65 percent of the amount paid for qualified health insurance for such month, and

''(ii) the amount contributed by the insurer to a qualified health savings account of the taxpayer does not exceed 27 percent of the amount in effect under subsection (b)(2)(A) for such month.

''(3) QUALIFIED HEALTH SAVINGS ACCOUNT.—

''(A) IN GENERAL.—The term 'qualified health savings account' means a health savings account (as defined in section 223(d))—

''(i) which is designated (in such form as the Secretary may prescribe) as a qualified account for purposes of this section,

''(ii) which may not include any amount other than contributions described in this subsection and earnings on such contributions, and

''(iii) with respect to which section 223(f)(4)(A) is applied by substituting '100 percent' for '10 percent'.

''(B) SUBACCOUNTS AND SEPARATE ACCOUNTING.—The Secretary may prescribe rules under which a subaccount within a health savings account, or separate accounting with respect to contributions and earnings described in subparagraph (A)(ii), may be treated in the same manner as a qualified health savings account.

''(C) ROLLOVERS.—A contribution of a distribution from a qualified health savings account to another health savings account shall be treated as a rollover contribution for purposes of section 223(f)(5) only if the other account is a qualified health savings account.

''(f) DEPENDENTS.—For purposes of this section—

''(1) DEPENDENT DEFINED.—The term 'dependent' has the meaning given such term by section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof).

''(2) SPECIAL RULE FOR DEPENDENT CHILD OF DIVORCED PARENTS.—An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

''(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151(c) is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(g) INFLATION ADJUSTMENTS.—

''(1) CREDIT AND HEALTH INSURANCE AMOUNTS.—In the case of any taxable year beginning after 2006, each dollar amount referred to in subsections (b)(1)(B), (b)(2)(A), (d)(3)(B), and (d)(4)(C)(iii)(I) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins, determined by substituting '2005' for '1996' in subclause (II) thereof.

If any amount as adjusted under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME PHASEOUT AMOUNTS.—In the case of any taxable year beginning after 2006, each dollar amount referred to in paragraph (3) and (4) of subsection (b) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2005' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as adjusted under the preceding sentence is not a multiple of $50, such amount shall be rounded to the next lowest multiple of $50.

''(h) ARCHER MSA CONTRIBUTIONS; HSA CONTRIBUTIONS.—If a deduction would be allowed under sec-

tion 220 to the taxpayer for a payment for the taxable year to the Archer MSA of an individual or under section 223 to the taxpayer for a payment for the taxable year to the Health Savings Account of such individual, subsection (a) shall not apply to the taxpayer for any month during such taxable year for which the taxpayer, spouse, or dependent is an eligible individual for purposes of either such section.

''(i) OTHER RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL EXPENSE AND PREMIUM DEDUCTIONS FOR HIGH DEDUCTIBLE HEALTH PLANS.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 or 224 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(2) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—No credit shall be allowable under this section for a taxable year if a deduction is allowed under section 162(l) for the taxable year.

''(3) COORDINATION WITH ADVANCE PAYMENT.—Rules similar to the rules of section 35(g)(1) shall apply to any credit to which this section applies.

''(4) COORDINATION WITH SECTION 35.—If a taxpayer is eligible for the credit allowed under this section and section 35 for any taxable year, the taxpayer shall elect which credit is to be allowed.

''(j) EXPENSES MUST BE SUBSTANTIATED.—A payment for insurance to which subsection (a) applies may be taken into account under this section only if the taxpayer substantiates such payment in such form as the Secretary may prescribe.

''(k) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following:

''SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the

return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

"(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage,

"(C) the aggregate amount of payments described in subsection (a), and

"(D) such other information as the Secretary may reasonably prescribe.

"(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(d)).

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such

amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xiii) through (xviii) as clauses (xiv) through (xix), respectively, and by inserting after clause (xii) the following:

''(xiii) section 6050U (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (AA), by striking the period at the end of the subparagraph (BB) and inserting '', or'', and by adding at the end the following:

''(CC) section 6050U(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting

after the item relating to section 6050T the following:

''Sec. 6050U. Returns relating to payments for qualified health insurance.''.

(c) CRIMINAL PENALTY FOR FRAUD.—Subchapter B of chapter 75 of the Internal Revenue Code of 1986 (relating to other offenses) is amended by adding at the end the following:

''SEC. 7276. PENALTIES FOR OFFENSES RELATING TO HEALTH INSURANCE TAX CREDIT.

''Any person who knowingly misuses Department of the Treasury names, symbols, titles, or initials to convey the false impression of association with, or approval or endorsement by, the Department of the Treasury of any insurance products or group health coverage in connection with the credit for health insurance costs under section 36 shall on conviction thereof be fined not more than $10,000, or imprisoned not more than 1 year, or both.''.

(d) CONFORMING AMENDMENTS.—

(1) Section 162(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) ELECTION TO HAVE SUBSECTION APPLY.—No deduction shall be allowed under paragraph (1) for a taxable year unless the taxpayer elects to have this subsection apply for such year.''.

(2) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ", or from section 36 of such Code".

(3) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking "35" and inserting "36" and by inserting after the item relating to section 35 the following:

"Sec. 36. Health insurance costs for uninsured individuals.".

(4) The table of sections for subchapter B of chapter 75 of such Code is amended by adding at the end the following:

"Sec. 7276. Penalties for offenses relating to health insurance tax credit.".

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2005.

(2) PENALTIES.—The amendments made by subsections (c) and (d)(4) shall take effect on the date of the enactment of this Act.

SEC. 202. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

''Not later than July 1, 2007, the Secretary shall establish a program for making payments to providers of qualified health insurance (as defined in section 36(d)) on behalf of individuals eligible for the credit under section 36. Such payments shall be made on the basis of modified adjusted gross income of eligible individuals for the preceding taxable year.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 7529. Advance payment of health insurance credit for purchasers of qualified health insurance.''.

Subtitle B—High Deductible Health Plans and Health Savings Accounts

SEC. 211. DEDUCTION OF PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

"(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction for the taxable year the aggregate amount paid by or on behalf of such individual as premiums under a high deductible health plan with respect to months during such year for which such individual is an eligible individual with respect to such health plan.

"(b) DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' has the meaning given such term by section 223(c)(1).

"(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' has the meaning given such term by section 223(c)(2).

"(c) SPECIAL RULES.—

"(1) DEDUCTION ALLOWABLE FOR ONLY 1 PLAN.—For purposes of this section, in the case of an individual covered by more than 1 high deductible health plan for any month, the individual may only take into account amounts paid for 1 of such plans for such month.

"(2) GROUP HEALTH PLAN COVERAGE.—

"(A) IN GENERAL.—No deduction shall be allowed to an individual under subsection (a)

for any amount paid for coverage under a high deductible health plan for a month if, as of the first day of that month, that individual participates in any coverage under a group health plan (within the meaning of section 5000 without regard to section 5000(d)).

''(B) EXCEPTION FOR CERTAIN PERMITTED COVERAGE.—Subparagraph (A) shall not apply to an individual if the individual's only coverage under a group health plan for a month is coverage described in clause (i) or (ii) of section 223(c)(1)(B).

''(3) MEDICARE ELIGIBLE INDIVIDUALS.—No deduction shall be allowed under subsection (a) with respect to any individual for any month if the individual is entitled to benefits under title XVIII of the Social Security Act for the month.

''(4) HEALTH SAVINGS ACCOUNT REQUIRED.—A deduction shall not be allowed under subsection (a) for a taxable year with respect to an individual unless the individual is an account beneficiary of a health savings account during a portion of the taxable year.

''(5) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Subsection (a) shall not apply with re-

spect to any amount which is paid or distributed out of an Archer MSA or a health savings account which is not included in gross income under section 220(f) or 223(f), as the case may be.

''(6) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE OF SELF-EMPLOYED INDIVIDUALS.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

''(7) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of the Internal Revenue Code of 1986 (defining adjusted gross income) is amended by inserting before the last sentence at the end the following new paragraph:

''(21) PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.—The deduction allowed by section 224.''.

(c) COORDINATION WITH HEALTH INSURANCE COSTS CREDIT.—Section 35(g)(2) of the Internal Rev-

enue Code of 1986 is amended by striking ''or 213'' and inserting '',213, or 224''.

(d) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 224 as section 225 and by inserting before such item the following new item:

''Sec. 224. Premiums for high deductible health plans.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2005.

SEC. 212. REFUNDABLE CREDIT FOR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS OF SMALL BUSINESS EMPLOYEES.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as amended by subtitle A, is amended by inserting after section 36 the following new section:

''SEC. 36A. SMALL EMPLOYER CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.

''(a) GENERAL RULE.—In the case of an eligible employer, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the lesser of—

''(1) the amount contributed by such employer to any qualified health savings account of any em-

ployee who is an eligible individual (as defined in section 223(c)(1)) during the taxable year, or

''(2) an amount equal to the product of—

''(A) $200 ($500 if coverage for all months described in subparagraph (B)(i) is family coverage), and

''(B) a fraction—

''(i) the numerator of which is the number of months that the employee was covered under a high deductible health plan maintained by the employer, and

''(ii) the denominator of which is the number of months in the taxable year.

''(b) ELIGIBLE EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible employer' means, with respect to any taxable year, an employer which—

''(A) is a small employer, and

''(B) maintains a high deductible health plan under which all employees of the employer reasonably expected to receive at least $5,000 of compensation during the taxable year are eligible to participate.

An employer may exclude from consideration under subparagraph (B) employees who are covered by an agreement described in section 410(b)(3)(A) if there is evidence that health benefits were the subject of good faith bargaining.

''(2) EXCEPTION FOR GOVERNMENTAL AND TAX-EXEMPT EMPLOYERS.—The term 'eligible employer' shall not include the Federal Government or any employer described in section 457(e)(1).

''(3) SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reason-

ably expected such employer will employ on business days in the current calendar year.

''(C) SPECIAL RULE.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(c) DEFINITIONS.—For purposes of this section—

''(1) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' has the meaning given such term by section 223(c)(2).

''(2) QUALIFIED HEALTH SAVINGS ACCOUNT.—

''(A) IN GENERAL.—The term 'qualified health savings account' means a health savings account (as defined in section 223(d))—

''(i) which is designated (in such form as the Secretary may prescribe) as a qualified account for purposes of this section,

''(ii) which may not include any amount other than contributions described in subsection (a) and earnings on such contributions, and

''(iii) with respect to which section 223(f)(4)(A) is applied by substituting '100 percent' for '10 percent'.

''(B) SUBACCOUNTS AND SEPARATE ACCOUNTING.—The Secretary may prescribe rules

under which a subaccount within a health savings account, or separate accounting with respect to contributions and earnings described in subparagraph (A)(ii), may be treated in the same manner as a qualified health savings account.

''(C) ROLLOVERS.—A contribution of a distribution from a qualified health savings account to another health savings account shall be treated as a rollover contribution for purposes of section 223(f)(5) only if the other account is a qualified health savings account.

''(d) SPECIAL RULES.—For purposes of this section—

''(1) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

''(2) DISALLOWANCE OF DEDUCTION.—No deduction shall be allowed for that portion of contributions to any health savings accounts for the taxable year which is equal to the credit determined under subsection (a).

''(3) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable

year if such taxpayer elects to have this section not apply for such taxable year.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36A of such Code''.

(2) The table of sections for subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986, as amended by subtitle A, is amended by inserting after the item relating to section 36 the following new item:

''Sec. 36A. Small employer contributions to health savings accounts.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions made in taxable years beginning after December 31, 2005.

Subtitle C—Improvement of the Health Coverage Tax Credit

SEC. 221. CHANGE IN STATE-BASED COVERAGE RULES RELATED TO PREEXISTING CONDITIONS.

(a) IN GENERAL.—Section 35(e)(2) of the Internal Revenue Code of 1986 (relating to requirements for State-based coverage) is amended by adding at the end the following:

''(C) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD.—The term 'qualified

health insurance' does not include any coverage described in subparagraphs (C) through (H) of paragraph (1) that imposes a pre-existing condition exclusion with respect to any individual unless—

"(i) such exclusion relates to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the date the individual seeks to enroll in the coverage,

"(ii) such exclusion extends for a period of not more than 12 months after the individual seeks to enroll in the coverage,

"(iii) the period of any such pre-existing condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (as defined in section 9801(c)) applicable to the individual as of the enrollment date, and

"(iv) such exclusion is not an exclusion described in section 9801(d).".

(b) CONFORMING AMENDMENTS.—

(1) INTERNAL REVENUE CODE OF 1986.—Subparagraph (A) of section 35(e)(2) of such Code is amended—

(A) by striking clause (ii); and

(B) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(2) WORKFORCE INVESTMENT ACT OF 1998 AMENDMENTS.—Section 173(f)(2)(B) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(f)(2)(B)) is amended—

(A) in clause (i)—

(i) by striking subclause (II); and

(ii) by redesignating subclauses (III) and (IV) as subclauses (II) and (III), respectively; and

(B) by adding at the end the following:

''(iii) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD.—The term 'qualified health insurance' does not include any coverage described in clauses (iii) through (ix) of subparagraph (A) that imposes a pre-existing condition exclusion with respect to any individual unless—

''(I) such exclusion relates to a physical or mental condition, regard-

less of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the date the individual seeks to enroll in the coverage;

''(II) such exclusion extends for a period of not more than 12 months after the individual seeks to enroll in the coverage;

''(III) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (as defined in section 9801(c) of the Internal Revenue Code of 1986) applicable to the individual as of the enrollment date; and

''(IV) such exclusion is not an exclusion described in section 9801(d) of such Code.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to taxable years beginning after December 31, 2005.

SEC. 222. ELIGIBILITY OF SPOUSE OF CERTAIN INDIVIDUALS ENTITLED TO MEDICARE.

(a) IN GENERAL.—Subsection (b) of section 35 of such Code (defining eligible coverage month) is amended by adding at the end the following:

''(3) SPECIAL RULE FOR SPOUSE OF INDIVIDUAL ENTITLED TO MEDICARE.—Any month which would be an eligible coverage month with respect to a taxpayer (determined without regard to subsection (f)(2)(A)) shall be an eligible coverage month for any spouse of such taxpayer, provided the spouse has attained age 55 and meets the requirements of clauses (ii), (iii), and (iv) of paragraph (1)(A).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to taxable years beginning after December 31, 2005.

SEC. 223. ELIGIBLE PBGC PENSION RECIPIENT.

(a) IN GENERAL.—Subparagraph (B) of section 35(c)(4) of such Code (relating to eligible PBGC pension recipients) is amended by inserting before the period the following '', or, after August 6, 2002, received from such Corporation a one-time single-sum pension payment in lieu of an annuity''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enact-

ment of section 201 of the Trade Act of 2002 (Public Law 107–210, 116 Stat. 954).

SEC. 224. APPLICATION OF OPTION TO OFFER STATE-BASED COVERAGE TO PUERTO RICO, NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM, AND THE UNITED STATES VIRGIN ISLANDS.

(a) IN GENERAL.—Section 35(e) of such Code (relating to requirements for qualified health insurance) is amended by adding at the end the following:

''(4) APPLICATION TO PUERTO RICO, NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM, AND THE UNITED STATES VIRGIN ISLANDS.—For purposes of this section, Puerto Rico, Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands shall be considered States.''.

(b) CONFORMING AMENDMENT.—Section 173(f)(2) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(f)(2)) is amended by adding at the end the following:

''(D) APPLICATION TO NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM, AND THE UNITED STATES VIRGIN ISLANDS.—For purposes of subsection (a)(4)(A) and this subsection, the term 'State' shall include the

Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to taxable years beginning after December 31, 2005.

SEC. 225. CLARIFICATION OF DISCLOSURE RULES.

(a) IN GENERAL.—Subsection (k) of section 6103 of such Code (relating to disclosure of certain returns and return information for tax administration purposes) is amended by adding at the end the following:

''(10) DISCLOSURE OF CERTAIN RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—The Secretary may disclose to providers of health insurance, administrators of health plans, or contractors of such providers or administrators, for any certified individual (as defined in section 7527(c)) the taxpayer identity and health insurance member and group numbers of the certified individual (and any qualifying family member as defined in section 35(d), if applicable) and the amount and period of the payment, to the extent the Secretary deems necessary for the administration of the program established by section 7527 (relating to ad-

vance payment of credit for health insurance costs of eligible individuals).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 6103 of such Code (relating to confidentiality and disclosure of returns and return information) is amended—

(A) in subsection (a)(3), by inserting ''(k)(10),'' after ''(e)(1)(D)(iii),'';

(B) in subsection (l), by striking paragraph (18); and

(C) in subsection (p)—

(i) in paragraph (3)(A)—

(I) by striking ''or (9)'' and inserting ''(9), or (10)''; and

(II) by striking ''(17), or (18)'' and inserting ''or (17)''; and

(ii) in paragraph (4), by striking ''(18)'' after ''(l)(16)'' each place it appears.

(2) Section 7213(a)(2) of such Code (relating to unauthorized disclosure of information) is amended by inserting ''(k)(10)'' before ''(l)(6)''.

(3) Section 7213A(a)(1)(B) of such Code (relating to unauthorized inspection of returns or return information) is amended by striking ''sub-

section (l)(18) or (n) of section 6103'' and inserting ''section 6103(n)''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to taxable years beginning after December 31, 2005.

SEC. 226. CLARIFICATION THAT STATE-BASED COBRA CONTINUATION COVERAGE IS SUBJECT TO SAME RULES AS FEDERAL COBRA.

(a) IN GENERAL.—Section 35(e)(2) of such Code (relating to state-based coverage requirements) is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''(B)'' and inserting ''(C)''; and

(2) in subparagraph(B)(i), by striking ''(B)'' and inserting ''(C)''.

(b) CONFORMING AMENDMENTS.—Section 173(f)(2)(B) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(f)(2)(B)) is amended—

(1) in clause (i), in the matter preceding subclause (I), by striking ''(ii)'' and inserting ''(iii)''; and

(2) in clause (ii)(I), by striking ''(ii)'' and inserting ''(iii)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enact-

ment of sections 201 and 203, respectively, of the Trade Act of 2002 (Public Law 107–210, 116 Stat. 954).

SEC. 227. APPLICATION OF RULES FOR OTHER SPECIFIED COVERAGE TO ELIGIBLE ALTERNATIVE TAA RECIPIENTS CONSISTENT WITH RULES FOR OTHER ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 35(f)(1) of such Code (relating to subsidized coverage) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(b) CONFORMING AMENDMENTS.—Section 173(f)(7)(A) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(f)(7)(A)) is amended by striking clause (ii) and redesignating clause (iii) as clause (ii).

Subtitle D—Long-Term Care Insurance

SEC. 231. SENSE OF THE SENATE CONCERNING LONG-TERM CARE.

It is the sense of the Senate that Congress should take steps to make long-term care more affordable by providing tax incentives for the purchase of long-term care insurance, support for family caregivers, and making necessary public program reforms.

Subtitle E—Other Provisions

SEC. 241. DISPOSITION OF UNUSED HEALTH BENEFITS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j), respectively, and by inserting after subsection (g) the following:

''(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH BENEFITS.—

''(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because qualified benefits under such plan include a health flexible spending arrangement under which not more than $500 of unused health benefits may be—

''(A) carried forward to the succeeding plan year of such health flexible spending arrangement, or

''(B) to the extent permitted by section 106(c), contributed by the employer to a health savings account (as defined in section 223(d)) maintained for the benefit of the employee.

"(2) HEALTH FLEXIBLE SPENDING ARRANGEMENT.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'health flexible spending arrangement' means a flexible spending arrangement (as defined in section 106(c)) that is a qualified benefit and only permits reimbursement for expenses for medical care (as defined in section 213(d)(1), without regard to subparagraphs (C) and (D) thereof).

"(B) FLEXIBLE SPENDING ARRANGEMENT.—A flexible spending arrangement is a benefit program which provides employees with coverage under which—

"(i) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

"(ii) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

''(3) UNUSED HEALTH BENEFITS.—For purposes of this subsection, with respect to an employee, the term 'unused health benefits' means the excess of—

''(A) the maximum amount of reimbursement allowable to the employee for a plan year under a health flexible spending arrangement, over

''(B) the actual amount of reimbursement for such year under such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2004.

SEC. 242. MICROENTREPRENEURS.

(Section 404(8) of the Assets for Independence Act (42 U.S.C. 604 note) is amended by adding at the end the following:

''(F) HIGH DEDUCTIBLE HEALTH INSURANCE.—

''(i) IN GENERAL.—The eligible individual's contribution (as an employer or employee) for coverage under a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986).

"(ii) DEFINITION OF EMPLOYEE.—For purposes of clause (i), the term 'employee' includes an individual described in section 401(c)(1) of the Internal Revenue Code of 1986.".

SEC. 243. STUDY ON ACCESS TO AFFORDABLE HEALTH INSURANCE FOR FULL-TIME COLLEGE AND UNIVERSITY STUDENTS.

(a) SENSE OF THE SENATE.—It is the sense of the Senate that, because a considerable number of the United States' uninsured population are young adults who are enrolled full-time at an institution of higher education, Congress should determine whether health care coverage proposals targeting this population would be effective.

(b) STUDY REQUIRED.—The Government Accountability Office shall provide for the conduct of a study to evaluate existing and potential sources of affordable health insurance coverage for graduate and undergraduate students enrolled at an institution of higher education (as defined in section 1201 of the Higher Education Act of 1965 (20 U.S.C. 1141)).

(c) REQUIRED ELEMENTS OF STUDY.—In conducting the study under subsection (b), the Government Accountability Office shall, at a minimum, examine the following:

(1) STUDENT DEMOGRAPHICS.—

(A) IN GENERAL.—The size and characteristics of the insured and uninsured population of undergraduate and graduate students enrolled at institutions of higher education. Such data shall be differentiated as provided for in subparagraphs (B) and (C).

(B) STATISTICAL BREAKDOWN.—The data concerning the uninsured student population collected under subparagraph (A) shall be differentiated by—

(i) the full-time, full-time equivalent, and part-time enrollment status of the students involved;

(ii) the type of institution involved (such as a public, private, non-profit, or community institution);

(iii) the length and type of educational program involved (such as a certificate or diploma program, a 2-year or 4-year degree program, a masters degree program, or a doctoral degree program); and

(iv) the undergraduate and graduate student populations involved.

(C) COVERAGE.—The data concerning the insured student population collected under subparagraph (A) shall be differentiated by the sources of coverage for such students, including the number and percentage of such insured students who lose parental (or other) coverage during the course of their enrollment at such institutions and the age at which such coverage is lost.

(2) IMPACT ANALYSIS.—The financial and other impact of uninsured students at such institutions, as compared to insured students, on—

(A) the health of students;

(B) the student's family;

(C) the student's educational progress; and

(D) education and health care institutions and facilities.

(3) ASSESSMENT OF EXISTING PROGRAMS.—The effect of mandatory and voluntary programs on the access of students to health insurance coverage, including—

(A) the level and type of coverage provided through mandatory and voluntary State and institutionally-sponsored health care programs

currently providing health care insurance coverage to students;

(B) the average premium paid with respect to students covered under such plans;

(C) the extent to which any State or institutional health insurance plan may serve as a model for the expansion of access to health insurance for all full-time undergraduate and graduate students attending an institution of higher education; and

(D) whether such programs targeted to the student population would be more effective in reducing the overall rate of uninsured relative to proposals targeted to broader populations.

(4) INCENTIVES AND DISINCENTIVES.—The existence of incentives and disincentives offered to institutions of higher education to expand access to health care coverage for students, including—

(A) an assessment of the types of incentives and disincentives that may be used to encourage or require an institution of higher education to include health care coverage for all of its students on a mandatory basis, including financial, regulatory, administrative, and other incentives or disincentives;

(B) a list of burdensome regulatory or administrative reporting and other requirements (from the Department of Education or other governmental agencies) that could be waived without compromising program integrity as a means of encouraging institutions of higher education to provide uninsured students with access to health care coverage;

(C) other incentives or disincentives that would increase the level of institutional participation in health care coverage programs; and

(D) an analysis of the costs and effectiveness (to reduce the number of uninsured students) of including the cost of health insurance as an allowable cost of attendance under the Higher Education Act of 1965, and the impact of such inclusion on the student's financial aid package.

(e) CONSULTATION WITH CONGRESS.—In carrying out the study under subsection (b), the Government Accountability Office shall consult on a regular basis with the Secretary of Education, the Secretary of Health and Human Services, the Committee on the Budget of the Senate, the Committee on Health, Education, Labor, and

Pensions of the Senate, and the Committee on Education and the Workforce of the House of Representatives.

(f) REPORT.—Not later than 1 year after the date of enactment of this Act, the Government Accountability Office shall prepare and submit to the Committee on the Budget and the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Education and the Workforce of the House of Representatives, a report concerning the results of the study conducted under this section.

SEC. 244. EXTENSION OF FUNDING FOR OPERATION OF STATE HIGH RISK HEALTH INSURANCE POOLS.

Section 2745 of the Public Health Service Act (42 U.S.C. 300gg–45) is amended to read as follows:

"SEC. 2745. PROMOTION OF QUALIFIED HIGH RISK POOLS.

"(a) EXTENSION OF SEED GRANTS TO STATES.—The Secretary shall provide from the funds appropriated under subsection (d)(1)(A) a grant of up to $1,000,000 to each State that has not created a qualified high risk pool as of the date of enactment of this section for the State's costs of creation and initial operation of such a pool.

"(b) GRANTS FOR OPERATIONAL LOSSES.—

''(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool that—

''(A) restricts premiums charged under the pool to no more than 150 percent of the premium for applicable standard risk rates;

''(B) offers a choice of two or more coverage options through the pool; and

''(C) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State after the end of fiscal year 2004 in connection with operation of the pool;

the Secretary shall provide, from the funds appropriated under subsection (d)(1)(B)(i) and allotted to the State under paragraph (2), a grant for the losses incurred by the State in connection with the operation of the pool.

''(2) ALLOTMENT.—The amounts appropriated under subsection (d)(1)(B)(i) for a fiscal year shall be made available to the States (or the entities that operate the high risk pool under applicable State law) as follows:

''(A) An amount equal to 50 percent of the appropriated amount for the fiscal year shall be allocated in equal amounts among each eligible

State that applies for assistance under this subsection.

''(B) An amount equal to 25 percent of the appropriated amount for the fiscal year shall be allocated among the States so that the amount provided to a State bears the same ratio to such available amount as the number of uninsured individuals in the State bears to the total number of uninsured individuals in all States (as determined by the Secretary).

''(C) An amount equal to 25 percent of the appropriated amount for the fiscal year shall be allocated among the States so that the amount provided to a State bears the same ratio to such available amount as the number of individuals enrolled in health care coverage through the qualified high risk pool of the State bears to the total number of individuals so enrolled through qualified high risk pools in all States (as determined by the Secretary).

''(c) BONUS GRANTS FOR SUPPLEMENTAL CONSUMER BENEFITS.—

''(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool, the Secretary shall provide, from the funds appropriated

under subsection (d)(1)(B)(ii) and allotted to the State under paragraph (3), a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk pools.

''(2) BENEFITS.—A State shall use amounts received under a grant under this subsection to provide one or more of the following benefits:

''(A) Low-income premium subsidies.

''(B) A reduction in premium trends, actual premiums, or other cost-sharing requirements.

''(C) An expansion or broadening of the pool of individuals eligible for coverage, including eliminating waiting lists, increasing enrollment caps, or providing flexibility in enrollment rules.

''(D) Less stringent rules, or additional waiver authority, with respect to coverage of pre-existing conditions.

''(E) Increased benefits.

''(F) The establishment of disease management programs.

''(3) LIMITATION.—In allotting amounts under this subsection, the Secretary shall ensure that no State receives an amount that exceeds 10 percent of the amount appropriated for the fiscal year involved under subsection (d)(1)(B)(ii).

''(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit States that, on the date of enactment of the State High Risk Pool Funding Extension Act of 2005, are in the process of implementing programs to provide benefits of the type described in paragraph (2), from being eligible for a grant under this subsection.

''(d) FUNDING.—

''(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are authorized and appropriated—

''(A) $15,000,000 for the period of fiscal years 2005 and 2006 to carry out subsection (a); and

''(B) $75,000,000 for each of fiscal years 2005 through 2009, of which—

''(i) two-thirds of the amount appropriated for a fiscal year shall be made available for allotments under subsection (b)(2); and

"(ii) one-third of the amount appropriated for a fiscal year shall be made available for allotments under subsection (c)(2).

"(2) AVAILABILITY.—Funds appropriated under this subsection for a fiscal year shall remain available for obligation through the end of the following fiscal year.

"(3) REALLOTMENT.—If, on June 30 of each fiscal year, the Secretary determines that all amounts appropriated under paragraph (1)(B)(ii) for the fiscal year are not allotted, such remaining amounts shall be allotted among States receiving grants under subsection (b) for the fiscal year in amounts determined appropriate by the Secretary.

"(4) NO ENTITLEMENT.—Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

"(e) APPLICATIONS.—To be eligible for a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(f) DEFINITIONS.—In this section:

"(1) QUALIFIED HIGH RISK POOL.—

"(A) IN GENERAL.—The term 'qualified high risk pool' has the meaning given such term in section 2744(c)(2), except that with respect to subparagraph (A) of such section a State may elect to provide for the enrollment of eligible individuals through—

"(i) a combination of a qualified high risk pool and an acceptable alternative mechanism; or

"(ii) other health insurance coverage described in subparagraph (B).

"(B) HEALTH INSURANCE COVERAGE.—Health insurance coverage described in this subparagraph is individual health insurance coverage—

"(i) that meets the requirements of section 2741;

"(ii) that is subject to limits on the rates charged to individuals;

"(iii) that is available to all individuals eligible for health insurance coverage under this title who are not able to participate in a qualified high risk pool; and

"(iv) the defined rate limit of which does not exceed the limit allowed for a

qualified risk pool that is otherwise eligible to receive assistance under a grant under this section.

''(C) OTHER COVERAGE.—In addition to coverage described in subparagraph (B), a State may provide for the offering of health insurance coverage that provides first dollar coverage, limits on cost-sharing, and comprehensive medical, hospital and surgical coverage, if the limits on rates for such coverage do not exceed 125 percent of the limit described in subparagraph (B)(iv).

''(2) STANDARD RISK RATE.—The term 'standard risk rate' means a rate—

''(A) determined under the State high risk pool by considering the premium rates charged by other health insurers offering health insurance coverage to individuals in the insurance market served;

''(B) that is established using reasonable actuarial techniques; and

''(C) that reflects anticipated claims experience and expenses for the coverage involved.

''(3) STATE.—The term 'State' means any of the 50 States and the District of Columbia.''.

SEC. 245. SENSE OF THE SENATE ON AFFORDABLE HEALTH COVERAGE FOR SMALL EMPLOYERS.

It is the sense of the Senate that Congress should pass legislation to support expanded, affordable health coverage options for individuals, particularly those who work for small businesses, by streamlining and reducing regulations and expanding the role of associations and other group purchasing arrangements.

Subtitle F—Covering Kids

SEC. 251. SHORT TITLE.

This subtitle may be cited as the ''Covering Kids Act of 2005''.

SEC. 252. GRANTS TO PROMOTE INNOVATIVE OUTREACH AND ENROLLMENT UNDER MEDICAID AND SCHIP.

(a) GRANTS FOR EXPANDED OUTREACH ACTIVITIES.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. EXPANDED OUTREACH ACTIVITIES.

''(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH AND ENROLLMENT EFFORTS.—

''(1) IN GENERAL.—The Secretary shall award grants to eligible entities to—

''(A) conduct innovative outreach and enrollment efforts that are designed to increase

the enrollment and participation of eligible children under this title and title XIX; and

''(B) promote understanding of the importance of health insurance coverage for prenatal care and children.

''(2) PERFORMANCE BONUSES.—The Secretary may reserve a portion of the funds appropriated under subsection (g) for a fiscal year for the purpose of awarding performance bonuses during the succeeding fiscal year to eligible entities that meet enrollment goals or other criteria established by the Secretary.

''(b) PRIORITY FOR AWARD OF GRANTS.—

''(1) IN GENERAL.—In making grants under subsection (a)(1), the Secretary shall give priority to—

''(A) eligible entities that propose to target geographic areas with high rates of—

''(i) eligible but unenrolled children, including such children who reside in rural areas; or

''(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

"(B) eligible entities that plan to engage in outreach efforts with respect to individuals described in subparagraph (A) and that are—

"(i) Federal health safety net organizations; or

"(ii) faith-based organizations or consortia.

"(2) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

"(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a)(1) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

"(1) quality and outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section to ensure that the activities are meeting their goals; and

''(2) an assurance that the entity shall—

''(A) conduct an assessment of the effectiveness of such activities against such performance measures; and

''(B) cooperate with the collection and reporting of enrollment data and other information determined as a result of conducting such assessments to the Secretary, in such form and manner as the Secretary shall require.

''(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

''(1) disseminate to eligible entities and make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(2)(B); and

''(2) submit an annual report to Congress on the outreach activities funded by grants awarded under this section.

''(e) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State or local government.

''(B) A Federal health safety net organization.

''(C) A national, local, or community-based public or nonprofit private organization.

''(D) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(E) An elementary or secondary school.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) an Indian tribe, tribal organization, or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider;

''(B) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

"(C) a hospital defined as a disproportionate share hospital for purposes of section 1923;

"(D) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

"(E) any other entity or a consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

"(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated,

$50,000,000 for each of fiscal years 2006 and 2007 for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsection (a)(1)(D)(iii) of that section.''.

(b) EXTENDING USE OF OUTSTATIONED WORKERS TO ACCEPT TITLE XXI APPLICATIONS.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by striking ''or (a)(10)(A)(ii)(IX)'' and inserting ''(a)(10)(A)(ii)(IX), or (a)(10)(A)(ii)(XIV), and applications for child health assistance under title XXI''.

SEC. 253. STATE OPTION TO PROVIDE FOR SIMPLIFIED DETERMINATIONS OF A CHILD'S FINANCIAL ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER MEDICAID OR CHILD HEALTH ASSISTANCE UNDER SCHIP.

(a) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13)(A) At the option of the State, the plan may provide that financial eligibility requirements

for medical assistance are met for a child who is under an age specified by the State (not to exceed 21 years of age) by using a determination made within a reasonable period (as determined by the State) before its use for this purpose, of the child's family or household income, or if applicable for purposes of determining eligibility under this title or title XXI, assets or resources, by a Federal or State agency, or a public or private entity making such determination on behalf of such agency, specified by the plan, including (but not limited to) an agency administering the State program funded under part A of title IV, the Food Stamp Act of 1977, the Richard B. Russell National School Lunch Act, or the Child Nutrition Act of 1966, notwithstanding any differences in budget unit, disregard, deeming, or other methodology, but only if—

"(i) the agency has fiscal liabilities or responsibilities affected or potentially affected by such determination; and

"(ii) any information furnished by the agency pursuant to this subparagraph is used solely for purposes of determining financial eligibility for medical assistance under this title or for child health assistance under title XXI.

''(B) Nothing in subparagraph (A) shall be construed—

''(i) to authorize the denial of medical assistance under this title or of child health assistance under title XXI to a child who, without the application of this paragraph, would qualify for such assistance;

''(ii) to relieve a State of the obligation under subsection (a)(8) to furnish medical assistance with reasonable promptness after the submission of an initial application that is evaluated or for which evaluation is requested pursuant to this paragraph;

''(iii) to relieve a State of the obligation to determine eligibility for medical assistance under this title or for child health assistance under title XXI on a basis other than family or household income (or, if applicable, assets or resources) if a child is determined ineligible for such assistance on the basis of information furnished pursuant to this paragraph; or

''(iv) as affecting the applicability of any non-financial requirements for eligibility for medical assistance under this title or child health assistance under title XXI.''.

(b) SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following:

''(E) Section 1902(e)(13) (relating to the State option to base a determination of child's financial eligibility for assistance on financial determinations made by a program providing nutrition or other public assistance).''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2005.

TITLE III—IMPROVING CARE AND STRENGTHENING THE SAFETY NET

Subtitle A—High Needs Areas

SEC. 301. PURPOSE.

It is the purpose of this subtitle to enhance the quality of life of residents of high need areas by increasing their access to the preventive and primary healthcare services provided by community health centers and rural health centers.

SEC. 302. HIGH NEED COMMUNITY HEALTH CENTERS.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) by redesignating subsections (k) through (r) as subsections (l) through (s), respectively;

(2) by inserting after subsection (j), the following:

''(k) PRIORITY FOR RESIDENTS OF HIGH NEED AREAS.—

''(1) IN GENERAL.—In awarding grants under this section, the Secretary shall give priority to eligible health centers in high need areas.

''(2) ELIGIBLE HEALTH CENTERS.—A health center is described in this paragraph if such health center—

''(A) is a health center as defined under subsection (a) or a rural health clinic that receives funds under section 330A;

''(B) agrees to use grant funds to provide preventive and primary healthcare services to residents of high need areas;

''(C) specifically requests such priority in the grant application;

''(D) describes how the community to be served meets the definition of high need area; and

''(E) otherwise meets all other grant requirements.

''(3) HIGH NEED AREA.—

"(A) IN GENERAL.—In this subsection, the term 'high need area' means a county or a regional area identified by the Secretary pursuant to the regulations promulgated under subparagraph (B).

"(B) REGULATIONS.—The Secretary shall promulgate regulations that define the term 'high need area' for purposes of this subsection. Such regulations shall specify procedures that the Department shall follow in determining estimates on a periodic basis in the United States of the number of medically uninsured persons and the national percentage of medically uninsured persons served by health centers (referred to in this subsection as the 'ENP') and for the designation of an area as a 'high need area' if the estimated percentage of medically uninsured individuals in the area is higher than the national average and the estimated percentage of medically uninsured individuals in the area served by health centers in the area is below the ENP.

"(C) MEDICALLY UNDERSERVED AREA.—The Secretary shall designate residents of high

need areas as medically underserved for purposes of this section.

''(4) FUNDING PREFERENCE.—The Secretary may limit the amount of grants awarded to applicants from high need areas as provided for in this subsection to not less than 25 percent of the total amount of grants awarded under this subsection for each grant category for each grant period.'';

(3) in subsection (e)(1)(B), by striking ''subsection (k)(3)'' and inserting ''subsection (l)(3)'';

(4) in subsection (l)(3)(H)(iii) (as so redesignated), by striking ''or (p)'' and inserting ''or (q)'';

(5) in subsection (m) (as so redesignated), by striking ''subsection (k)(3)'' and inserting ''subsection (l)(3)'';

(6) in subsection (q) (as so redesignated), by striking ''subsection (k)(3)(G)'' and inserting ''subsection (l)(3)(G)''; and

(7) in subsection (s)(2)(A) (as so redesignated), by striking ''subsection (k)'' each place that such appears and inserting ''subsection (l)''.

SEC. 303. GRANT APPLICATION PROCESS.

Section 330(k) of the Public Health Service Act (42 U.S.C. 254b(k)) is amended by adding at the end the following:

''(5) ECONOMIC VIABILITY OF APPLICANTS.—

''(A) IN GENERAL.—In considering applications under this section, the Secretary shall ensure that an application that demonstrates economic viability, consistent with funding guidelines established by the Secretary for purposes of this section, is not disadvantaged in the evaluation process on the basis that it relies solely on Federal funding.

''(B) QUALIFICATION OF INDIVIDUALS REVIEWING APPLICATIONS.—The Secretary shall require verification that all individuals who are evaluating community health center grant applications have completed within the 3-year period ending on the date on which the application is being evaluated a training course on the community health center program which addresses the purposes served by community health centers, the critical role of community health centers in the safety net, expectations for the evaluation of applications, and the criteria for awarding grant funding.

''(C) MEDICALLY UNDERSERVED DESIGNATIONS.—Not later than 6 months after the date of enactment of this paragraph, the Adminis-

trator of the Health Resources and Services Administration shall submit to the appropriate committees of Congress a report concerning the process for designating an area or population as medically underserved. Such report shall contain recommendations for ensuring that such designations are current within the last 3 years. The report shall also detail plans for ensuring subsequent review to maintain an accurate reflection of community needs in areas and populations designated as medically underserved. Not later than 1 year after such date of enactment, the Secretary shall promulgate regulations based on the recommendations contained in the report.''.

Subtitle B—Qualified Integrated Health Care systems

SEC. 321. GRANTS TO QUALIFIED INTEGRATED HEALTH CARE SYSTEMS.

(a) ELIGIBILITY FOR GRANTS UNDER PHSA.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

"Subpart XI—Promotion of Integrated Health Care Systems Serving Medically Underserved Populations

"SEC. 340H. GRANTS TO QUALIFIED INTEGRATED HEALTH CARE SYSTEMS.

''(a) DEFINITIONS.—For purposes of this section:

''(1) QUALIFIED INTEGRATED HEALTH CARE SYSTEM.—The term 'qualified integrated health care system' means an integrated health care system that—

''(A) has a demonstrated capacity and commitment to provide a full range of primary, specialty, and hospital care to a medically underserved population in both inpatient and outpatient settings, as appropriate;

''(B) is organized to provide such care in a coordinated fashion;

''(C) operates one or more integrated health centers meeting the requirements of section 340I;

''(D) meets the requirements of subsection (c)(3); and

''(E) agrees to use any funds received under this section to supplement and not to supplant amounts received from other sources for the provision of such care.

"(2) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given such term in section 330(b)(3).

"(b) OPERATING GRANTS.—

"(1) AUTHORITY.—The Secretary may make grants to private nonprofit entities for the costs of the operation of qualified integrated health care systems that provide primary, specialty, and hospital care to medically underserved populations.

"(2) AMOUNT.—

"(A) IN GENERAL.—The amount of any grant made in any fiscal year under paragraph (1) to an integrated health care system shall be determined by the Secretary (taking into account the full range of care, including specialty services, provided by the system), but may not exceed the amount by which the costs of operation of the system in such fiscal year exceed the total of—

"(i) State, local, and other operational funding provided to the system; and

"(ii) the fees, premiums, and third-party reimbursements which the system

may reasonably be expected to receive for its operations in such fiscal year.

''(B) PAYMENTS.—Payments under grants under paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments.

''(C) USE OF NONGRANT FUNDS.—Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.

''(c) APPLICATIONS.—

''(1) SUBMISSION.—No grant may be made under this section unless an application therefore is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe.

''(2) DESCRIPTION OF NEED.—

"(A) IN GENERAL.—An application for a grant under subsection (b)(1) for an integrated health care system shall include—

"(i) a description of the need for health care services in the area served by the integrated health care system;

"(ii) a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services; and

"(iii) a demonstration that the health care system will be located so that it will provide services to the greatest number of individuals residing in such area or included in such population group.

"(B) DEMONSTRATIONS.—A demonstration shall be made under clauses (ii) or (iii) of subparagraph (A) on the basis of the criteria prescribed by the Secretary under section 330(b)(3) or on the basis of any other criteria which the Secretary may prescribe to determine if the area or population group to be served by the applicant has a shortage of personal health services.

''(C) CONDITION OF APPROVAL.—In considering an application for a grant under subsection (b)(1), the Secretary may require as a condition to the approval of such application an assurance that any integrated health center operated by the applicant will provide any required primary health services and any additional health services (as defined in section 340I) that the Secretary finds are needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided to the applicant.

''(3) REQUIREMENTS.—The Secretary shall approve an application for a grant under subsection (b)(1) if the Secretary determines that the entity for which the application is submitted is an integrated health care system (within the meaning of subsection (a)) and that—

''(A) the primary, specialty, and hospital care provided by the system will be available and accessible in the service area of the system promptly, as appropriate, and in a manner which assures continuity;

"(B) the system is participating (or will participate) in a community consortium of safety net providers serving such area (unless other such safety net providers do not exist in a community, decline or refuse to participate, or place unreasonable conditions on their participation);

"(C) all of the centers operated by the system are accredited by a national accreditation body recognized by the Secretary;

"(D) the system will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

"(E) the system provides or will provide services to individuals who are eligible for medical assistance under title XIX of the Social Security Act and to individuals who are eligible for assistance under title XXI of such Act;

"(F) the system—

"(i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be

applied to the payment of such fees or payments, and which discounts are adjusted on the basis of the patient's ability to pay;

''(ii)(I) will assure that no patient will be denied health care services due to an individual's inability to pay for such services; and

''(II) will assure that any fees or payments required by the system for such services will be reduced or waived to enable the system to fulfill the assurance described in subclause (I); and

''(iii) has submitted to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph;

''(G) the system has established a governing board that selects the services to be provided by the center, approves the center's annual budget, approves the selection of a director for the center, and establishes general policies for the center;

''(H) the system has developed—

''(i) an overall plan and budget that meets the requirements of the Secretary; and

''(ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to—

''(I) the costs of its operations;

''(II) the patterns of use of its services;

''(III) the availability, accessibility, and acceptability of its services; and

''(IV) such other matters relating to operations of the applicant as the Secretary may require;

''(I) the system will review periodically its service area to—

''(i) ensure that the size of such area is such that the services to be provided through the system (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

"(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

"(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the system, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

"(J) in the case of a system which serves a substantial proportion of individuals of limited English-speaking ability, the system has—

"(i) developed a plan and made arrangements for providing services, to the extent practicable, in the predominant language or languages of such individuals and in the cultural context most appropriate to such individuals; and

"(ii) identified one or more individuals on its staff who are fluent in such predominant language or languages and in

English and whose responsibilities shall include providing guidance to such individuals and to other appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;

''(K) the system maintains appropriate referral relationships between its hospitals, its physicians with hospital privileges, and any integrated health center operated by the system so that primary, specialty care, and hospital care is provided in a continuous and coordinated way; and

''(L) the system encourages persons receiving or seeking health services from the system to participate in any public or private (including employer-offered) health programs or plans for which the persons are eligible, so long as the center, in complying with this paragraph, does not violate the requirements of subparagraph (F)(ii)(I).

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as

may be necessary for each of fiscal years 2006 through 2010.

''(2) FUNDING REPORT.—The Secretary shall annually prepare and submit to the appropriate committees of Congress a report concerning the distribution of funds under this section that are provided to meet the health care needs of medically underserved populations, and the appropriateness of the delivery systems involved in responding to the needs of the particular populations. Such report shall include an assessment of the relative health care access needs of the targeted populations and the rationale for any substantial changes in the distribution of funds.

''(e) RECORDS.—

''(1) IN GENERAL.—Each entity which receives a grant under subsection (b)(1) shall establish and maintain such records as the Secretary shall require.

''(2) AVAILABILITY.—Each entity which is required to establish and maintain records under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable re-

quest therefore. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

''(f) AUDITS.—

''(1) IN GENERAL.—Each entity which receives a grant under this section shall provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

''(A) the entity's implementation of the guidelines established by the Secretary respecting cost accounting;

''(B) the processes used by the entity to meet the financial and program reporting requirements of the Secretary; and

"(C) the billing and collection procedures of the entity and the relation of the procedures to its fee schedule and schedule of discounts and to the availability of health insurance and public programs to pay for the health services it provides.

A report of each such audit shall be filed with the Secretary at such time and in such manner as the Secretary may require.

"(2) RECORDS.—Each entity which receives a grant under this section shall establish and maintain such records as the Secretary shall by regulation require to facilitate the audit required by paragraph (1). The Secretary may specify by regulation the form and manner in which such records shall be established and maintained.

"(3) AVAILABILITY OF RECORDS.—Each entity which is required to establish and maintain records or to provide for an audit under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying, or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The

Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

''(4) WAIVER.—The Secretary may, under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an entity.

"SEC. 340I. INTEGRATED HEALTH CENTER.

''(a) INTEGRATED HEALTH CENTER.—The term 'integrated health center' means an health center that is operated by an integrated health care system and that serves a medically underserved population (as defined for purposes of section 330(b)(3)) by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements—

''(1) required primary health services (as defined in subsection (b)(1)); and

''(2) as may be appropriate for particular centers additional health services (as defined in subsection (b)(2)) necessary for the adequate support of the primary health services required under paragraph (1);

for all residents of the area served by the center.

''(b) DEFINITIONS.—For purposes of this section:

''(1) REQUIRED PRIMARY HEALTH SERVICES.—The term 'required primary health services' means—

''(A) basic health services which, for purposes of this section, shall consist of—

''(i) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;

''(ii) diagnostic laboratory and radiologic services;

''(iii) preventive health services, including—

''(I) prenatal and perinatal services;

''(II) appropriate cancer screening;

''(III) well-child services;

''(IV) immunizations against vaccine-preventable diseases;

''(V) screenings for elevated blood lead levels, communicable diseases, and cholesterol;

''(VI) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;

''(VII) voluntary family planning services; and

''(VIII) preventive dental services;

''(iv) emergency medical services; and

''(v) pharmaceutical services and medication therapy management services as may be appropriate for particular centers;

''(B) referrals to providers of medical services (including specialty and hospital care referrals when medically indicated) and other health-related services (including substance abuse and mental health services);

''(C) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially sup-

port the provision of medical, social, housing, educational, or other related services;

"(D) services that enable individuals to use the services of the center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the languages spoken by a predominant number of such individuals); and

"(E) education of patients and the general population served by the center regarding the availability and proper use of health services.

"(2) ADDITIONAL HEALTH SERVICES.—The term 'additional health services' means services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the center involved. Such term may include—

"(A) behavioral and mental health and substance abuse services;

"(B) recuperative care services; and

"(C) environmental health services.".

(b) COVERAGE UNDER THE MEDICARE PROGRAM.—

(1) PART B BENEFIT.—Section 1861(s)(2)(E) of the Social Security Act (42 U.S.C. 1395x(s)(2)(E)) is amended—

(A) by striking ''services and'' and inserting ''services,''; and

(B) by striking ''services'' the second place it appears and inserting ''services, and integrated health center services''.

(2) DEFINITIONS.—Section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)) is amended—

(A) in the heading—

(i) by striking ''SERVICES AND'' and inserting ''SERVICES,''; and

(ii) by striking ''SERVICES'' the second place it appears and inserting ''SERVICES, AND INTEGRATED HEALTH CENTER SERVICES'';

(B) in paragraph (1)(B), by striking ''paragraph (5))'' and inserting ''paragraph (7));

(C) by redesignating paragraphs (5), (6), and (7) as paragraphs (7), (8), and (9), respectively; and

(D) by inserting after paragraph (4) the following new paragraph:

''(5) The term 'integrated health center services' means—

''(A) services of the type described in subparagraphs (A) through (C) of paragraph (1); and

''(B) preventive primary health services that a center is required to provide under section 340I of the Public Health Service Act,

when furnished to an individual as an outpatient of an integrated health center, and for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to an integrated health center or a physician at the center, respectively.

''(6) The term 'integrated health center' means a center that is operated by a qualified integrated health care system (as defined in section 340H(a)(1) of the Public Health Service Act that—

''(A) is receiving a grant under section 340H of such Act; or

''(B) is determined by the Secretary to meet the requirements for receiving such a grant.''.

(3) PAYMENT.—

(A) IN GENERAL.—Section 1832(a)(2)(D) of the Social Security Act (42 U.S.C. 1395k(a)(2)(D)) is amended—

(i) by striking ''and (ii)'' and inserting '', (ii)''; and

(ii) by striking ''services'' the second place it appears and inserting ''services, and (iii) integrated health center services.''.

(B) PART B DEDUCTIBLE DOES NOT APPLY.—Section 1833(b)(4) of the Social Security Act (42 U.S.C. 13951(b)(4)) is amended by inserting ''or integrated health center services'' after ''Federally qualified health center services''.

(C) EXCLUSION FROM PAYMENT REMOVED.—The second sentence of section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by inserting ''or integrated health center services described in section 1861 (aa)(5)(B)'' after ''section 1861(aa)(3)(B)''.

(D) WAIVER OF ANTI-KICKBACK RESTRICTION.—Section 1128B(b)(3)(D) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)(D)) is

amended by inserting ''or by an integrated health center'' after ''Federally qualified health center''.

(4) CONFORMING AMENDMENTS.—(A) Clauses (ii) and (iv) of section 1834(a)(1)(E) of the Social Security Act (42 U.S.C. 1395m(a)(1)(E)) are each amended by striking ''section 1861(aa)(5)'' and inserting ''section 1861(aa)(7)''.

(B) Section 1842(b)(18)(C)(i) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)(i)) is amended by striking ''section 1861(aa)(5)'' and inserting ''section 1861(aa)(7)''.

(C) Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(i) in subparagraph (H)(i), by striking ''subsection (aa)(5)'' and inserting ''subsection (aa)(7)''; and

(ii) in subparagraph (K)—

(I) by striking ''subsection (aa)(5)'' each place it appears and inserting ''subsection (aa)(7)''; and

(II) by striking ''subsection (aa)(6)'' and inserting ''subsection (aa)(8)''.

(D) Section 1861(dd)(3)(B) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(B)) is amended by

striking ''subsection (aa)(5)'' and inserting ''subsection (aa)(7)''.

(c) RECOGNITION UNDER MEDICAID.—

(1) COVERAGE.—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended—

(A) by striking ''and (C)'' and inserting '', (C)''; and

(B) by inserting '', and

''(D) integrated health center services (as defined in subsection (1)(3)(A)) and any other ambulatory services offered by the integrated health center and which are otherwise included in the plan.'' after ''included in the plan'' the second place it appears.

(2) DEFINITIONS.—Section 1905(l) of such Act (42 U.S.C. 1396d(l)) is amended by adding at the end the following:

''(3)(A) The term 'integrated health center services' means services of the type described in subparagraphs (A) through (C) of section 1861(aa) when furnished to an individual as a patient of an integrated health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed

a reference to an integrated health center or a physician at the center, respectively.

''(B) The term 'integrated health center' means a center that is operated by a qualified integrated health care system that—

''(i) is receiving a grant under section 340H of the Public Health Service Act; or

''(ii) is determined by the Secretary, based on the recommendations of the Administrator of the Centers for Medicare & Medicaid Services, to meet the requirements for receiving such a grant.''.

(3) PAYMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (15), by inserting ''and for services described in clause (D) of section 1905(a)(2) in accordance with the provisions of subsection (cc)'' after ''subsection (bb)''; and

(B) by adding at the end the following:

''(cc) PAYMENT FOR SERVICES PROVIDED BY INTEGRATED HEALTH CENTERS.—

''(1) IN GENERAL.—Beginning with fiscal year 2006 with respect to services furnished on or after January 1, 2006, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(D) furnished by an

integrated health center in accordance with the provisions of this subsection.

''(2) FISCAL YEAR 2006.—Subject to paragraph (4), for services furnished on and after January 1, 2006, during fiscal year 2006, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center of furnishing such services during fiscal years 2004 and 2005 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center during fiscal years 2004 and 2005.

''(3) FISCAL YEAR 2007 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2007 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for

such services under this subsection for the preceding fiscal year—

"(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for that fiscal year; and

"(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center during that fiscal year.

"(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS.—In any case in which an entity first qualifies as an integrated health center after fiscal year 2006, the State plan shall provide for payment for services described in section 1905(a)(2)(D) furnished by the center in the first fiscal year in which the center so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers located in the same or adjacent area with a similar case load or, in the absence of such a center, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following

the fiscal year in which the entity first qualifies as an integrated health center, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—

''(A) IN GENERAL.—In the case of services furnished by an integrated health center pursuant to a contract between the center and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) exceeds the amount of the payments provided under the contract.

''(B) PAYMENT SCHEDULE.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the integrated health center, but in no case less frequently than every 4 months.

''(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in

any fiscal year to an integrated health center for services described in section 1905(a)(2)(D) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center; and

''(B) results in payment to the center of an amount which is at least equal to the amount otherwise required to be paid to the center under this section.''.

(4) WAIVER PROHIBITED.—Section 1915(b) of the Social Security Act (42 U.S.C.1396n(b)) is amended in the matter preceding paragraph (1), by inserting ''1902(cc),'' after ''1902(bb),''.

(d) PROTECTION AGAINST LIABILITY.—Section 224(g) of the Public Health Service Act (42 U.S.C. 233(g)) is amended—

(1) In paragraph (4), by striking ''An entity'' and inserting ''Subject to paragraph (6), an entity''; and

(2) by adding at the end the following:

''(6) For purposes of this section—

''(A) a qualified integrated health care system receiving a grant under section 340H and any integrated health center operated by such system shall

be considered to be an entity described in paragraph (4); and

''(B) the provisions of this section shall apply to such system and centers in the same manner as such provisions apply to an entity described in such paragraph (4), except that—

''(i) notwithstanding paragraph (1)(B), the deeming of any system or center, or of an officer, governing board member, employee, or contractor of such system or center, to be an employee of the Public Health Service for purposes of this section shall apply only with respect to items and services that are furnished to a member of the underserved population served by the entity;

''(ii) notwithstanding paragraph (3), this paragraph shall apply only with respect to causes of action arising from acts or omissions that occur on or after January 1, 2006; and

''(iii) the Secretary shall make separate estimates under subsection (k)(1) with respect to such systems and centers and entities described in paragraph (4) (other than such systems and centers), establish separate funds under subsection (k)(2) with respect to such groups of

entities, and any appropriations under this subsection for such systems and centers shall be separate from the amounts authorized by subsection (k)(2).''.

(e) EFFECTIVE DATE.—The amendments made subsections (b) and (c) shall apply to items and services furnished on or after October 1, 2005.

Subtitle C—Miscellaneous Provisions

SEC. 331. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

''(s) MISCELLANEOUS PROVISIONS.—

''(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free

or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

''(B) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

''(i) nondiscrimination based upon the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 332. IMPROVEMENTS TO SECTION 340B PROGRAM.

(a) ELIMINATION OF GROUP PURCHASING PROHIBITION FOR CERTAIN HOSPITALS.—Section 340B(a)(4)(L) of the Public Health Service Act (42 U.S.C. 256b(a)(4)(L)) is amended—

(1) in clause (i), by adding ''and'' at the end;

(2) in clause (ii), by striking ''; and'' and inserting a period; and

(3) by striking clause (iii).

(b) PERMITTING USE OF MULTIPLE CONTRACT PHARMACIES.—Section 340B f the Public Health Service

Act (42 U.S.C. 256b) is amended by adding at the end the following:

''(e) PERMITTING USE OF MULTIPLE CONTRACT PHARMACIES.—Nothing in this section shall be construed as prohibiting a covered entity from entering into contracts with more than one pharmacy for the provision of covered drugs, including a contract that—

''(1) supplements the use of an in-house pharmacy arrangement; or

''(2) requires the approval of the Secretary.''.

(c) IMPROVEMENTS IN PROGRAM ADMINISTRATION.—Section 340B of the Public Health Service Act (42 U.S.C. 256b), as amended by subsection (b), is further amended by adding at the end the following:

''(f) IMPROVEMENTS IN PROGRAM ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary shall provide, from funds appropriated under paragraph (2), for improvements in the integrity and administration of the program under this section in order to prevent abuse and misuse of discounted prices made available under this section. Such improvements shall include the following:

''(A) The development of a system to verify the accuracy of information regarding covered

entities that is listed on the Internet website of the Department of Health and Human Services relating to this section.

''(B) The establishment of a third-party auditing system by which covered entities and manufacturers are regularly audited to ensure compliance with the requirements of this section.

''(C) The conduct of such audits under subsection (a)(5)(C) that supplement the audits conducted under subparagraph (B) as the Secretary determines appropriate and the implementation of dispute resolution guidelines and other compliance programs.

''(D) The development of more detailed guidance regarding the definition of section 340B patients and describing options for billing under the medicaid program under title XIX of the Social Security Act in order to avoid duplicative discounts.

''(E) The issuance of advisory opinions within defined time periods in response to questions from manufacturers or covered entities regarding the application of the requirements of this section in specific factual circumstances.

"(F) Insofar as the Secretary determines feasible, providing access through the Internet website of the Department of Health and Human Services on the prices for covered drugs made available under this section, but only in a manner (such as through the use of password protection) that limits such access to covered entities.

"(G) The improved dissemination of educational materials regarding the program under this section to covered entities that are not currently participating in such programs including regional educational sessions.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2006 and each succeeding fiscal year.".

SEC. 333. FORBEARANCE FOR STUDENT LOANS FOR PHYSICIANS PROVIDING SERVICES IN FREE CLINICS.

(a) IN GENERAL.—Section 428(c)(3)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (III), by striking ''or'' at the end;

(B) in subclause (V), by adding ''or'' at the end; and

(C) by adding at the end the following:

''(V) is volunteering without pay for at least 80 hours per month at a free clinic as defined under section 224 of the Public Health Service Act;''; and

(2) in clause (ii)(III), by inserting ''or (i)(V)'' after ''clause (i)(III)''.

(b) PERKINS PROGRAM.—Section 464(e) of the Higher Education Act of 1965 (20 U.S.C. 1087dd(e)) is amended—

(1) in paragraph (1), by striking ''or'' at the end;

(2) in paragraph (2), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(3) the borrower is volunteering without pay for at least 80 hours per month at a free clinic as defined under section 224 of the Public Health Service Act.''.

SEC. 334. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO LIABILITY.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (A)—

(i) in the first sentence, by striking ''or employee'' and inserting ''employee, or (subject to subsection (k)(4)) volunteer practitioner''; and

(ii) in the second sentence, by inserting ''and subsection (k)(4)'' after ''subject to paragraph (5)''; and

(B) by adding at the end the following:

''(I) For purposes of this subsection, the term 'employee' shall include a health professional who volunteers to provide health-related services for an entity described in paragraph (4).'';

(2) in subsection (k), by adding at the end the following:

''(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

''(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

''(i) The practitioner is a licensed physician or a licensed clinical psychologist.

''(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

''(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).'';

(3) in subsection (o)(2)—

(A) in subparagraph (D), by striking clause (i) and inserting the following:

''(i) The health care practitioner may provide the services involved as an employee of the free clinic, or may receive repayment from the

free clinic only for reasonable expenses incurred by the health care practitioner in the provision of the services to the individual.''; and

(B) by adding at the end the following:

''(G) The health care practitioner is providing the services involved as a paid employee of the free clinic.''; and

(4) in each of subsections (g), (i), (j), (k), (l), and (m), by striking ''employee, or contractor'' each place such term appears and inserting ''employee, volunteer practitioner, or contractor''.

SEC. 335. SENSE OF THE SENATE CONCERNING HEALTH DISPARITIES.

It is the sense of the Senate that additional measures are needed to reduce or eliminate disparities in health care related to race, ethnicity, socioeconomic status, and geography that affect access to quality health care.

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